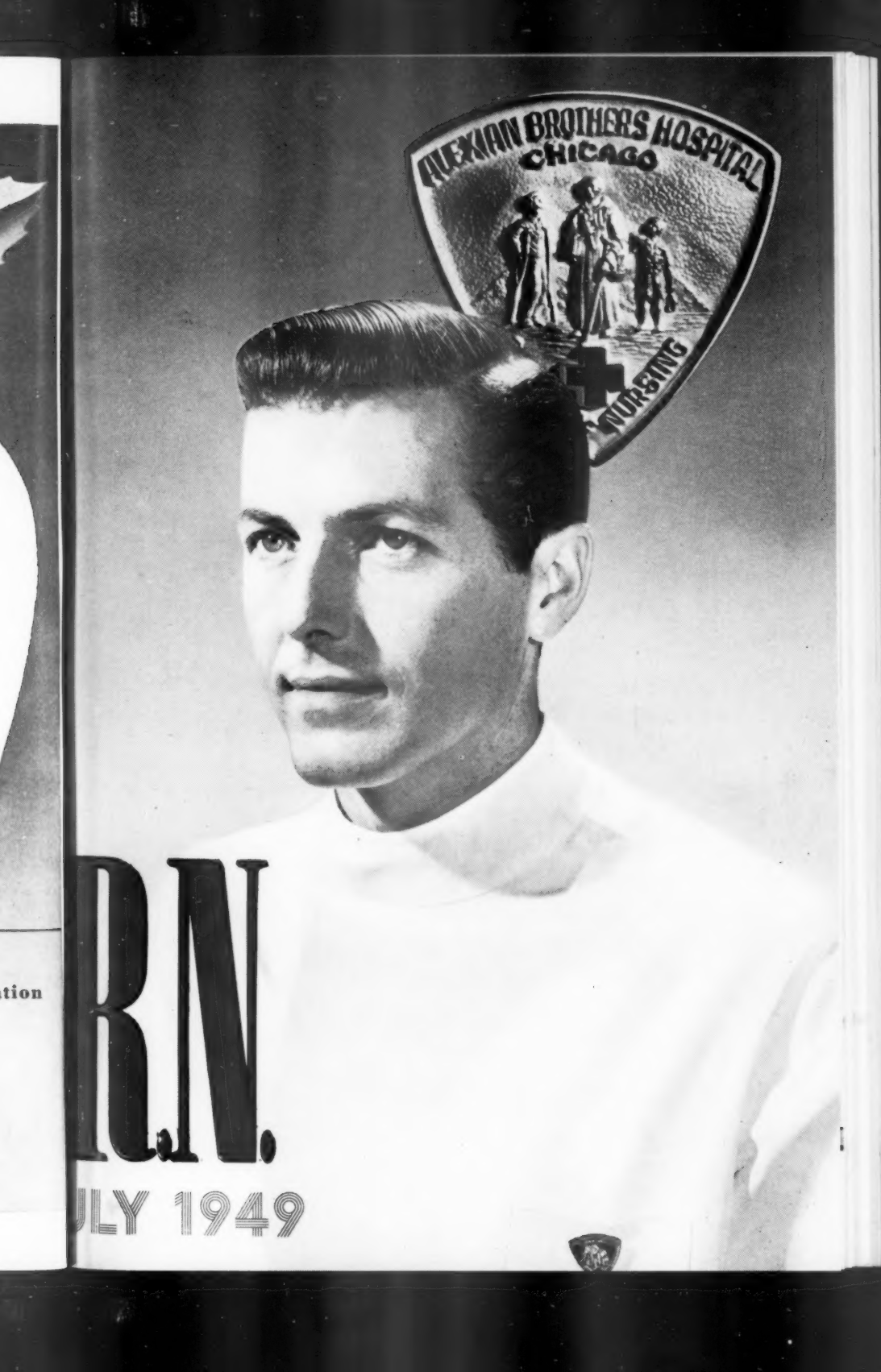
ALEXIAN BROTHERS HOSPITAL
CHICAGO
NURSING
R.N.
ULY 1949

all Eve's daughters

are susceptible to pruritus vulvae, a distressing symptom with many pos causes. Etiologic investigation may take time, but the patient can be re promptly—and safely—with CALMITOL Ointment.

PROMPTLY, *because* the active antipruritic agents of Calmitol—camp ated chloral, hyoscyamine oleate and menthol—immediately inhibit pruritic impulse at its origin by raising the sensation threshold of skin re tors and nerve endings;

and SAFELY, *because* the Calmitol formula carefully excludes such p tially dangerous agents as phenol, cocaine, and cocaine derivativ CALMITOL Ointment is completely free of stimulating, traumatizin keratolytic drugs.

CALMITOL

recommended whenever itching must be controlled, be it pruritus vulvae or other pruritic afflictions

1. Underwood, G. B., and Gaul, L. E.: J.A *138*:570, 1948.
2. Underwood, G. B.; Gaul, L. E.; C and Mosby, M.: J.A.M.A. *130*:249, 194
3. Andrews, G. C.: Diseases of the Skin delphia, W. B. Saunders Co., 1946.
4. Gaul, L. E.: J.A.M.A. *127*:439, 1945.

Thos. Leeming & Co., Inc. 155 East 44th Street, New York 17, N. Y.

R.N. CONTENTS

july, 1949
vol. 12, no. 10

features

departments

cover credits

Photographer: Walter Herstatt

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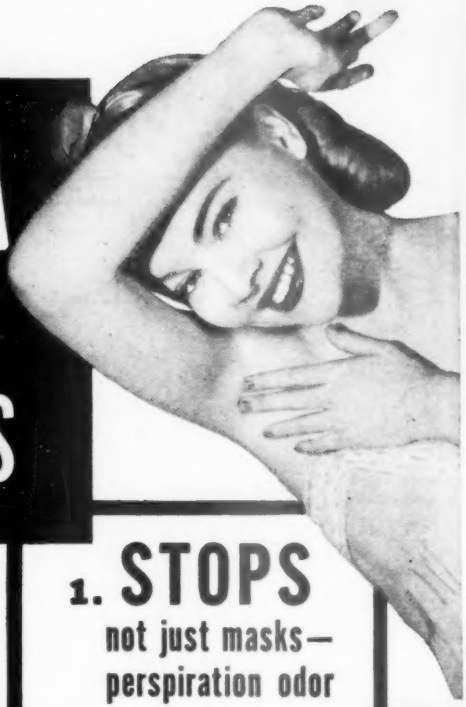
TWO WAYS



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not just masks—
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and beautifies
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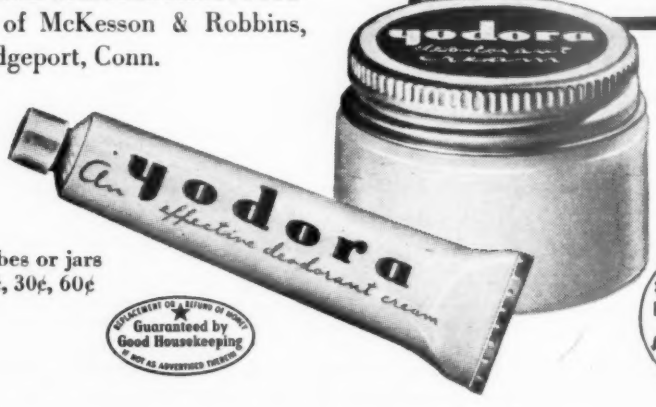

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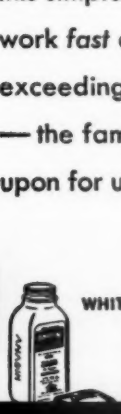

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DEBITS & CREDITS

On "What Price Reality?"

Dear Editor:

Your editorial "What Price Reality?" [**R.N.**, April] should wake up R.N.'s and give them food for thought. I am heartily in favor of practical nurses and licensing them. They have a definite place in the care of the sick. I am also in favor of higher education and degrees in nursing—but only for those who aspire to administrative or instructive positions.

During the war years I trained 250 nurses' aides and most of my girls turned out to be very good practical nurses. But good as they are, they still cannot take the place of an R.N. The basic training they received and their five years of experience have not begun to teach them the fundamentals necessary to replace any R.N. I do not agree with the idea that bedside care should be allocated solely to practical nurses—that it is a waste of time and training for R.N.'s to do such menial tasks daily. From personal experience with 23 years in nursing service I still find it vital to the patients' welfare to have professional care in bedside service. I can find out more of the patients' troubles and pains and general condition while giving a bath or taking a temperature then I could ever possibly do just visiting and asking questions. And I know more of what is important and necessary to report to the doctor than any practical could ever know.

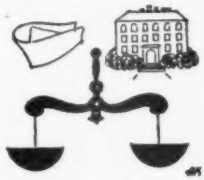
I would say the profession is in a bad way right now, and if the "powers that be" would take time out and consult patients in hospitals and homes they would find their answer. The public needs—right now—far better R.N. nursing care, better supervisors and restrictions on practical nurses. It's high time to come down out of the clouds and stop day dreaming. Let's stop patting ourselves on the back and get down to fundamentals and impress firmly on students their responsibilities toward their patients. We have shorter hours and more pay and instead of better care we seem to be giving inferior care.

MRS. M. CAROLYN GEISER, R.N.
SNIDERTON, PA.

*

Dear Editor:

I regret that time does not permit a letter lengthy enough to show my full appreciation for your editorial. Suffice to say, I am immensely pleased with your stand. I have talked with your so-called "theorists"



16, N.Y.

and walked away frustrated. Armchair planners forget, sometimes, to keep their feet on the ground. I feel strongly on this issue and could say much more, but for now, just thanks. Thanks for thinking clearly, for having your feet on the ground, and thanks especially for presenting our ideas.

M. V. G. SMITH, R.N.
MAYVIEW, PA.

*

Dear Editor:

I would like to present a great big beautiful orchid to you for your editorial. At last there is someone who is level headed and farsighted enough not to be clouded by the dim views of our "theorists."

Nursing has truly reached a critical point in its history if bedside nursing, by far the most important field of the profession, is to be tossed upon the shoulders of those with the minimal amount of training, education and general preparation.

Speaking as one who has had experience as a head nurse, I would rather have three well prepared nurses (student or graduate) than half a dozen non-professional nurses (student or graduate). I say this with all due respect to the practical nurse, because I see her as a person of value in the home, but *not* in the hospital. She should be taking care of convalescents, invalids and new mothers and their babies. In the hospital, where nursing is becoming more complex and the needs are more and more for highly skilled professional personnel, we have ward clerks to help us with the "book

How mild can a cigarette be?

DOCTORS REPORT

In a recent test of hundreds of people who smoked only Camels for 30 days, noted throat specialists, making weekly examinations, reported

"NOT ONE SINGLE CASE OF THROAT IRRITATION DUE TO SMOKING—CAMELS!"

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"I MADE MY OWN PERSONAL 30-DAY TEST! NOW I KNOW—CAMELS ARE THE MILDEST, BEST-TASTING CIGARETTE I EVER SMOKED!"

Sylvia MacNeill

SECRETARY

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According to a Nationwide survey:

More Doctors smoke **Camels**

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When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel

work" and phones, and we have nurses' aides to help us with tasks such as keeping the ward neat and clean, feeding patients, helping with difficult patients and, as a whole, being an aide to the professional nurse in every sense of the word, without performing bedside nursing.

If we continue to have practical nurses in the hospitals, wearing professional uniforms, our standards of nursing care are definitely going to take a downward slump. In the long run this will not only make nursing conditions in hospitals undesirable for professional nurses, but it will hurt the community.

Why not launch a more extensive campaign to interest the women who are better prepared to enter the field of professional nursing, and do all that can be done to make it more attractive for them!

MRS. PAULINE SCHWARTZ, R.N.
DETROIT, MICH.

*

Dear Editor:

After reading "What Price Reality?" I want to express my deep and sincere admiration and gratitude for your courageous article of facts that only a small percentage of us have dared to admit to ourselves and put into words to others—at the cost of being labeled radical and aggressive.

M. BLANCHE ADAMS, R.N.
MIAMI, FLA.

In the Beginning . . .

Dear Editor:

Your recent announcement to have a male nurse on a cover made me

POTENCY

The comprehensive controls under which we make Bayer Aspirin insure uniform potency. In all, over seventy different tests and inspections are employed in making this best-known of all analgesics. Bayer's reputation and acceptance as *the* analgesic for home use is being jealously guarded. In one of America's finest drug plants where Bayer Aspirin is made, *excellence* is the standard.

very happy. Since then I have been reading the comments of various readers. The letter of Mr. A. Levine [R.N., April] somewhat chagrined me. Is he ashamed to have male nurses publicized? Most of the laity think a male nurse is just some ugly ruffian or "queer" individual in a white coat who is nothing more than an orderly. Few people realize the type of training they receive and the many important positions they have in the profession and in other professions. Within my own sphere of acquaintances are men now engaged in many fields of endeavor—but they all got their start as an R.N. and are proud to say so. In fact, they say that if it had not been for their R.N. degree, they never would have had the opportunities and contacts that led to their success. The list includes a number of M.D.'s, a director of a college, a director of nursing education, industrial and public health workers, personnel managers, public relations men, research workers, lay hospital superintendents, detail men for drug firms, hardware dealers and many more. I wonder if many people are aware of the role that men nurses played in building up the pharmacist mate corps of the Maritime Service in World War II?

As for myself, I owe a great deal to my nurse background. It enabled me to work nights and pay the expenses of a B.A. and M.S. in biology which led to a teaching fellowship in biology at one of the larger universities. Next year about this time I hope to be able to write after my name, R.N., B.A., M.S., M.D.—and

Iron and the 6-weeks check-up!

THE STORE OF IRON a baby is born with, as you know, starts to diminish during the baby's second month!

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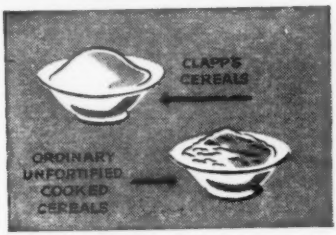
Clapp's is finer in texture



Clapp's finer texture is easier to digest—ideal for bottle and spoon feeding. Clapp's Cereals dissolve almost immediately in warm milk or formula. These are the reasons many doctors give when they recommend Clapp's Baby Cereals.

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I am darned proud and happy to have the R.N.

R.N., NEW YORK, N.Y.

Heated Collars

Dear Editor:

When I read such statements as the one attributed to Brig. General George E. Armstrong [R.N., Nov.], I wonder just how ignorant one must be in order to become "high brass."

In my nearly two years' service in the U.S. Navy Hospital Corps as a Pharmacist's Mate, the most "intimate office" or "quasi-menial service" I saw rendered to a patient was that of accompanying a medical officer on his rounds. All questions about the condition of the patient were referred to a senior corpsman who was required to make morning rounds with the nurse and medical officer.

Ninety-nine per cent of the bedside nursing was performed by corpsmen, some of whom had not more than three months' training given by more experienced corpsmen.

HARRY J. PARMENTER, R.N.
KANKAKEE STATE
HOSPITAL, ILL.

*

Dear Editor:

I was considerably surprised to find in your enjoyable, progressive publication an agreement with an attitude which belittles services rendered by nurses, particularly now when there is so much concern about gaining and sustaining professional status. The editors' note [R.N., Nov.] giving reasons for not commissioning men R.N.'s reminded me of the

Typical nurse's uniform 1880

Styles change...

but surveys show nurses ***still*** prefer:

1. WHITENESS IN A WHITE SHOE CLEANER
2. GRIFFIN ALLWITE OVER ALL OTHER BRANDS

Once again surveys show the one thing nurses from coast-to-coast want most in a white shoe cleaner is *whiteness*. That's why more nurses prefer Griffin Allwite over all other brands.

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To keep your white shoes new-looking, get Griffin Allwite . . . in the convenient bottle or the handy tube. With the nurses of America—Griffin Allwite is tops!

10¢ & 25¢ bottles • 15¢ & 25¢ tubes

GRIFFIN ALLWITE

late Mayor La Guardia's wish to classify nurses as "domestics." No doubt Brig. General Armstrong's motivation is similar: obtaining cheap professional services.

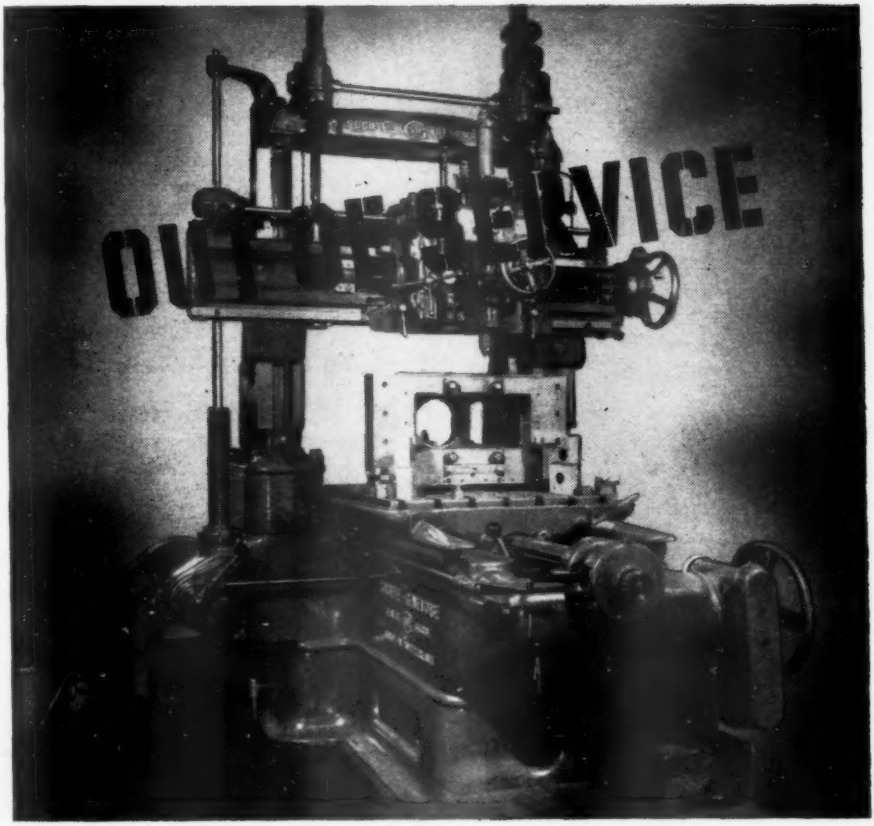
If I construe the General's meaning correctly in regard to "intimate offices," who could better accord male patients this care than men; and what sort of reasoning is this that implies that "women of officer rank" are somehow better endowed by reason of their sex "to render these services without incongruity"? I recall how WAC's and enlisted men performed the major portion of the so-called "intimate offices and quasi-menial services" cited as being such important phases of nursing. It is a known fact that in emergencies men R.N.'s assumed duties usually assigned to ANC officers.

A recent article propounded the theory that the male nurse is often more able to establish rapport with male patients in Veterans hospitals. The question arose: Why in the VA but not in the Army?

The significant thing to me was to find those who would guide the thinking of nurses subscribing to an attitude which disparages all nurses in order to defend a purely prejudicial stand.

PAUL B. SPRUNGER, R.N.
BELLEVUE HOSPITAL,
NEW YORK, N.Y.

[*Mr. Sprunger evidently misconstrued the editors' note. It emphatically was not an endorsement of Brig. Gen. Armstrong's viewpoint. See this month's editorial.*—THE EDITORS.]



An *itch* stopped this machine

It might have been the new cutting oil that gave Joe the rash. Maybe the picnic ground last Sunday was dotted with pretty green poison ivy plants. Or maybe Joe is hypersensitive to insect bites.

Joe is home today. He feels as though someone were holding a blowtorch on him. His highly specialized machine will stand idle until the burning, maddening itch is relieved and he can get back on the job.

Dermesthetic Ointment*—CUTTER

—will give triple-action itch relief while the underlying cause is being treated. Three anesthetic agents** offer fast, overlapping, and prolonged topical anesthesia. The base is greaseless and washable, no bandage is required, and normal work routines continue uninterrupted.

Your CUTTER supplier can furnish Dermesthetic Ointment in 1⅛ oz. tubes and 1 lb. jars.

Your request for clinical samples will be welcomed. Write CUTTER LABORATORIES, Berkeley 10, California, Dept. G-73.

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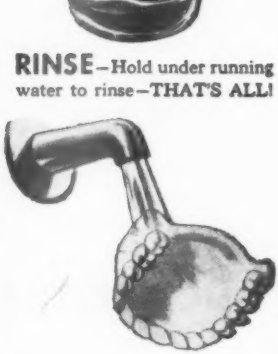

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trying your patients' patience?

– try palatable
Swift's Strained Meats

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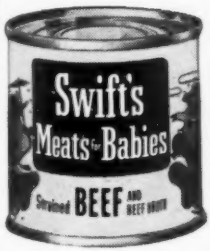

6 varieties

The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physician's handbook of protein feeding, written by a doctor. Send to:

To perk up patients' interest in food, many doctors prescribe specially prepared Swift's Strained Meats when soft foods are indicated in a high-protein, low-residue diet. They help two ways. *One*, Swift's Strained Meats taste so good. *Two*, an excellent source of B vitamins, Swift's Strained Meats help restore patients' natural appetite for all foods.

Swift's Strained Meats are soft, smooth (may easily be used in tube-feeding), slightly salted—cooked to retain their delicious meat flavor. Six kinds: beef, lamb, pork, veal, liver, heart. Each one 100% meat, they provide an excellent, palatable source of complete, high-quality proteins and hemapoietic iron. These meats make available *simultaneously* all known essential amino acids . . . for optimum protein synthesis.

SWIFT & COMPANY
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For patients who can take foods of less fine consistency—Swift's Diced Meats offer tender morsels of nutritious meat with tempting flavors patients appreciate.

sheer beauty
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SCIENCE SHORTS

A *JAMA* article states that post-operative lung infections due to the presence of bacteria in the respiratory tract before operation can be easily and effectively reduced by inhaling, before and after operation, small doses of micronized penicillin or streptomycin through a special suction apparatus.

*

Cutter Laboratories announce a new product, d-Tubocurarine Chloride Solution, a curare preparation to be used as a skeletal muscle relaxant in shock therapy, anesthesia, spastic and neurologic diseases and tetanus.

*

Penicillin salve has proved more effective than silver nitrate drops as a safeguard against blindness in the newborn, according to Dr. Nicholson J. Eastman of Johns Hopkins Hospital, who suggests that the state laws directing the instillation of silver nitrate drops be changed.

*

Lung stones, calcium deposits on healed-over scar tissue, once a rare disease, is becoming more common, Dr. Eugene Freedman of Los Angeles told the Radiological Society.

*

Soviet biologists with the approval of the Kremlin have rejected the Mendelian theory that only inherited characteristics can be transmitted to succeeding generations, in favor of the idea that plants and animals can acquire new inheritable properties from the environment.

*

U.S. Department of Agriculture's Bureau of Animal Industry recently reported death of a Washington zoo elephant from human type of pulmonary tuberculosis, and suggested that elephants may transmit Tb. among man and animals.

*

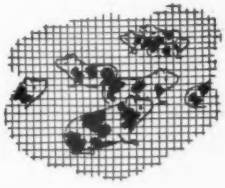
Magnifications, 50 times greater than those of ordinary microscopes, can be obtained by the new RCA electron microscope which, instead of using an ordinary beam of light, illuminates the specimen with a stream of electrons generated by a heated wire filament.

*

Malaria should be completely eliminated by the prophylactic and therapeutic use of chloroquine (Aralen), Dr. Maurice L. Taintor, director of the Sterling-Winthrop Research Institute, recently declared.

*

Five atomic scientists have developed cataracts from exposing their eyes to the neutron beams of a cyclotron. The cataracts resulted from



damage to the lens of the eye, one of the four tissues most sensitive to such radiation. The other three sensitive tissues consist of the white blood cells, the male reproductive cells, and the cells lining the intestinal tract.

*

Children are absent 7 per cent of the school year, 6 per cent of that for medical reasons, particularly respiratory diseases, common colds and communicable diseases, a recent study of 8,000 California school children by the Metropolitan Life Insurance Co. revealed.

*

Early postoperative ambulation is not a matter of getting the patient up on the second or third day after surgery, states Dr. Daniel J. Leithauser of Detroit. A patient should walk for at least two short periods the day of operation in order to induce normal muscle tone and glandular function.

*

A new vitamin in the wheat germ increases resistance to infection, it has been announced by Dr. Harry A. Schneider of the Rockefeller Institute for Medical Research.

*

An alarming post-war increase in heroin consumption in Finland, Italy, New Zealand, Sweden and Australia is caused by giving unnecessary prescriptions of the drug for respiratory diseases, the Central Opium Board of the United Nations stated recently. The use of heroin, a dangerously addicting opiate, is banned by 25 other countries including the U.S.

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Attention to personal details
is particularly important
in summer. Simple, routine use of
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keep fresh, neat, and self-confident,
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Pleasantly scented, soothing,
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Without charge, please send me a trial packet of Bo-Car-Al
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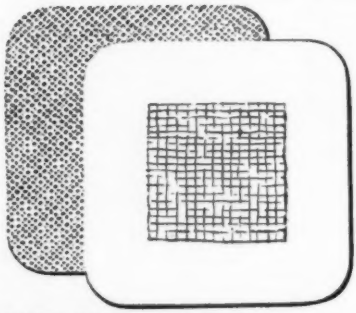

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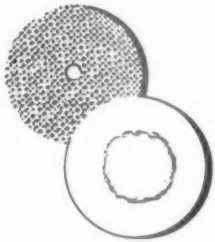
Ideal for: face lacerations—head and scalp wounds—parenteral injections—puncture wounds—boils—blisters. Dressing warts, moles, small sebaceous cysts—hand lacerations—Patch Testing.



2. BAND-AID Spot Dressings

Circular occlusive dressings, ¾" diameter

Ideal for: hypodermic and parenteral injections—blood tests—puncture wounds—small facial wounds—dressing of small skin lesions such as furuncles, corns or callouses, warts, moles, ingrown hairs.

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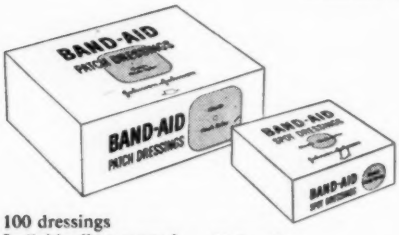

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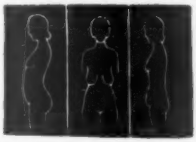

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R.N. Speaks: THE OPEN DOOR

May 22, 1943
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APO 41

My dear "Lady":

I have so much that I want to say that I can't find words to say it. We have changed our location again and I have a much better surgery now than I have ever had before. I am fully satisfied with our O.R. abilities. The other night, just about dark, a call came through that a gun shot in the stomach was coming in.

He had about a two-and-a-half mile drive. By the time he got to us we were ready for him. We used intravenous anesthesia. He had 19 holes in his intestines. It was quite a case. I had two boys for circulating and I scrubbed with Capt. ————. That was some job. I was kept pretty busy all through. In the middle of it all [censored] I don't know whether all will get through or not.

I know I sound like a braggart, but I hope that you don't mind if I brag a little, do you? You are the only one that I like to brag to, for in an indirect manner whatever I do while I am up here reflects on you. It is the same as if you were here beside me whenever anything turns up. I always say to myself, "If 'Lady' was here, would she do it this way or that?" Then I go ahead and do it the way I think you would.

The only thing that I hate is that I had to leave so soon. You taught me a lot and if I had been able to stay I am sure you could have taught me a lot more. It sure is a good thing that I knew you before I came up here. Again I want to say thanks for everything.

Always,
Johnny

* * *

This letter and others like it mean more to me than any military decoration, but that is not the reason I've published this particular letter.

Johnny was one of the medical corpsmen in my outfit overseas. Ours was an Army mobile surgical hospital, made up of medical per-

POLICY?

sonnel from all over the U.S., that sailed for the Southwest Pacific soon after Pearl Harbor. When the full complement finally reached Australia, we discovered that all of the medical, surgical, laboratory and x-ray technicians, who had been sent to school for training in the States, had been left behind.

For the two years that I served with this particular unit, I was chief nurse of surgery and taught operating room technique to boys like Johnny who had never set foot inside a hospital, let alone an operating room.

Johnny's case was typical. He was a Southerner of about 19, although he looked closer to 16 or 17, who, one day while on a cleaning detail around the O.R. tents, expressed an interest in working in surgery. At the first case he witnessed, a routine appendectomy, he keeled over. Being the persevering kid that we found him to be, he came back again and again until he was over his squeamishness.

We taught Johnny all the O.R. technique we could possibly pour into him in the short time he was with us.

The Japs, only 32 miles from Port Moresby on Sept., 1942, had been run into the sea at Buna by Jan., 1943 but respite had been nil for another campaign was under way. The American 32nd Division had been in the first counterattack, the 41st was now at Sanananda and Salamaua. We had only two divisions in the theatre. Trained surgical technicians were at a premium and the Army nurses as far as Port Moresby were not permitted to cross the towering Owen Stanley range as yet.

By the time Johnny had been in surgery six brief weeks, we were asked for the best technician we had. He was to join a portable hospital unit in combat to head up a team of surgical technicians. Johnny, even in that short time, was the best we had; that was undeniable. He seemed to have been born with an aseptic conscience. That which had been the most difficult to teach to the others came easily to Johnny. He possessed uncanny intuitive powers, sensing the surgeon's request before he made it—this was evident early in his training.

Although we all looked upon Johnny as a "natural," when I thought of him in New Guinea under combat condi- [*Continued on page* 57]

CANDID COMMENTS—THE

IS OUR MORAL CRISIS due to the advances of science?" This question dominated the mid-century convocation held recently at Cambridge, Mass. Eminent scientists, statesmen, philosophers, educators and industrialists came from 11 countries to ponder "The Social Implications of Scientific Progress." One conclusion was that while man is winning the battle against Nature, he is in danger of losing the battle against himself. Another was that "we must be brought back to a re-discovery of the true ends of human life through ethical awareness and religious faith."

Science has no soul; man has. Therefore science cannot meet all the needs of men. The Cambridge question has special meaning for medicine and nursing where the spectacular advances of science have increasingly absorbed our attention.

We are facing the greatest moral crisis in our history—moral because it involves more than economics and education. It involves hewing to the central purpose of nursing—the adequate care of patients—and relating every problem and objective directly to that purpose. The moment any problem or objective is treated apart from this core, that moment we are in danger. I believe that the pressures of science, of patient overloads, of self interest, and the confusions of the times, have precipitated a real moral crisis in nursing.

Medical science is steadily placing heavier scientific duties on both student and graduate nurses. There are more facts to learn, more techniques to master. And the art of nursing, which coordinates, inspirits and completes the nursing process, gets scant attention.

One result of this is that the patient is unnaturally divided into two parts—one requiring "skilled" care, the other getting along on "routine" care. Science is not solely responsible for this division; hospital economics and pressures have helped too. Another result is imbalance in student education. The student is robbed of an important part of her* education when the "routine" care of patients assigned to non-professional help includes all of the bedside nursing duties.

A more costly result lies in the development of an attitude of superiority toward personalized care. There are no menial tasks related to the care of patients, but how often we hear the word! In a recent hot de-

*For convenience the feminine is used throughout in referring to the nurse but it's understood that this applies to men nurses as well.

THE MORAL CRISIS IN NURSING

by Janet M. Geister, R.N.

bate over the practical nurse, one group said, "Sure, we're for the practical nurse. She'll do the work and we will supervise." This attitude toward "routine" care may account too for some of the disparaging views on private duty. Private duty, like many other things, needs fixing, but I hold to the belief that long after we're dust there will be some form of independent, personalized care of patients by professional nurses. The recent creation in medicine of the General Practitioners Academy is a sign in the sky. It bears watching.

Today's problems, huge and complex as they are, are transitory. They are of the times; for the most part they are due to growing pains. But nursing itself is timeless; its forward march is inexorable for it is an essential service to humanity. The reforms we need in personnel practices and nursing education will come, for today the public realizes the essentiality of skilled nursing. Tomorrow the public will recognize its responsibilities in its production and preservation. But the wisdom needed to meet these problems must first come from within nursing. Our ability to weigh old values as we set up new objectives, and above all to keep our heads and hearts in the right place, will set the pace of our progress.

We devote much attention, for example, to nurses' economic security. Let it be said quickly that I stand second to none in zeal for better pay and better conditions. Long before it was good manners to ask openly for justice for nurses, I was pleading for it on the platform and in editorials. The long and shameful exploitation of nurses' willingness to sacrifice must end. Although needful sacrifices should still go on, the needless ones related to low grade personnel practices must stop if the profession is adequately to serve the public.

Yet if good pay for nurses is vital to good patient care, then good patient care is vital to good pay for nurses. We cannot separate the security of the nurse from the security of the patient, for the patient is the very reason for the nurse's existence. Some hospital administrators, instead of recognizing that nursing shortages can be materially eased by reforms in personnel practices, seem to be using the shortage as an excuse for bringing in every type of non-professional help. This myopia is inexcusable, yet at the same time there are nurses so sorry for themselves, so intent on improving their lot, that pay, not patients, is the center of their universe.

This is certainly not true of the majority. We can gather anywhere

to talk economic security, and in a few moments nurses are telling of their unhappiness and worry over today's patient care. Dollars in themselves provide only temporary security. Enduring security can come only from matching the demand for rewards with a quality of service that justifies them. "I say flatly that we're sunk," says a fair-minded nursing director, "unless we restore good patient care and nurses' responsibility in providing it. We pay top salaries but we are not getting top service."

Another matter related to our crisis is the hospital use of non-professional help. The profession has not encouraged the tragic and indiscriminate use of help that ranges from a shuffling, half blind old man to the high school sophomore earning a few dollars after school. But we have encouraged the use of the practical nurse and therefore we have a responsibility for getting our own values straight. Can we arbitrarily divide nursing into "skilled" and "routine" segments? Aren't we thinking thus in terms of hospital economics and the workers involved rather than in terms of what the patient needs?

A first quality nurse from downstate Illinois says, "For the life of me I can't determine what 'routine' care is. Certainly there are jobs to be done by non-nurses, but I believe the division must be made wholly on the basis of the patient's need and not according to a set pattern. I asked an aide to place a pitcher of water on the bedside table of a cardiac patient. Later I went in to find a pitcher so heavy that even I had to strain to lift it. I've got to the point where I think that it's ward maids, errand girls, ward clerks that we need more than bedside helpers. I can't reconcile myself to this type of division of labor so I gave up my supervisory job and I'm now in private duty."

No thinking person denies the need for non-professional help. But the well trained practical nurse who knows her limitations is one thing—just anybody blundering about in the sacred realm of patient care is quite another. And until we get our own values straighter than they appear to be today and strike out sternly for better patient protection, we will continue to have the blunderers. The untrained "practical nurse" who gave three enemas in a row, *without returns,* to a new laparotomy case, is a menace, not a help. The high school girl who insisted on giving a patient with thrombosis a vigorous back rub because she'd been ordered to rub all backs, is another.

Surely there must be better ways of meeting the nursing shortage than by permitting our standards of patient protection to be destroyed. The profession is on trial, not the blunderers, for responsibility for the nursing care of American people is ours. The man who calls for staffs, "70 per cent practical nurses and 30 per cent graduates—otherwise how can you save money for new equipment" is guessing, and thinking only of the ledger, not the patient. Ethel A. Brooks, a Hartford, (Conn.) director of nursing, [*Continued on page* 67]

THE ALEXIAN BROTHERS

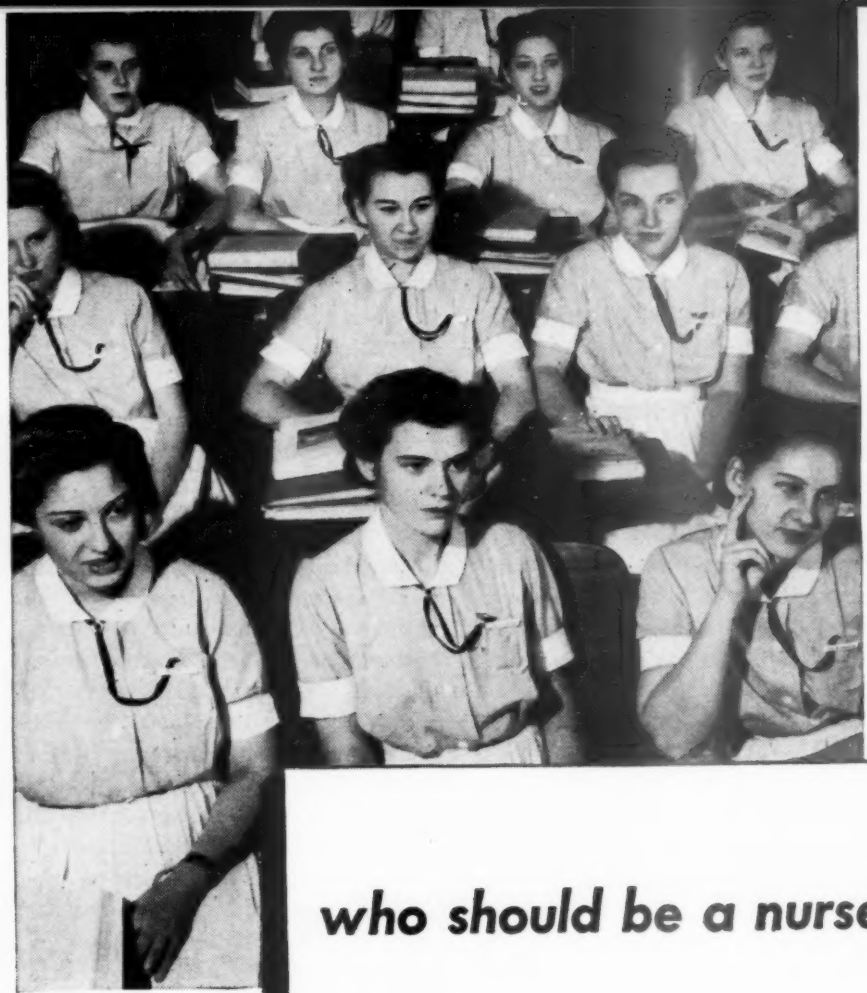
by Marion Scraver Gibba

■ IN RECOGNITION of the growing need for men nurses, there are today 123 state-accredited schools of nursing in the U.S. that accept men students. Two of these schools, exclusively for men, are conducted by the Alexian Brothers, a religious Congregation founded in the fourteenth century.

This month **R.N.**'s cover features the pin of the Alexian Brothers School of Nursing in Chicago which was founded in 1898, just 33 years after the Brothers had established their first general hospital for men and boys in the U.S. The three figures depicted on the pin—a boy, a crippled man, and a Brother—tell a graphic story of the work of this Congregation.

Thirty years later in 1928 the Alexian Brothers founded a school of nursing in St. Louis in connection with the hospital for men and boys they had established there in 1870. In keeping with nursing tradition they selected their own distinctive pin, in this instance a replica of the seal of the Congregation shown at the right. In the upper half of a shield, on a red background, there appears a pelican nourishing her young with her heart's blood—a symbol of the self-consuming sacrifice of Christian Charity. The bottom half is divided into two fields. At the left on a black background are two spades, a remembrance of the earliest occupation of the Congregation, that of burying the dead. To the right a flying raven is depicted on a silver-gray background. This represents the feeding of the destitute, a virtue the Community has practiced for centuries. From the back of the shield projects the cross indicating that in the cross is salvation. And banding the shield are the words of St. Paul: *Caritas Christi Urget Nos*—"The Charity of Christ presseth us."

Since the first concern of the Alexian Brothers is the care of the sick, it was inevitable that they took a vital interest in preparing young men to carry on their work in the field of nursing. Their two schools were established to meet the pressing demands for competent, trained men nurses—both laymen and Brothers. The Chicago Alexian school, accredited by the Illinois state board, is affiliated with De Paul University and many of its graduates continue their studies at the University to [*Continued on page* 64]



OWI Photo

who should be a nurse?

by Elizabeth C. Payne, R.N., B.S.

● WHO SHOULD BE a nurse? Many answer, "Those who have a high school diploma, are 18 years of age and in good physical health." Others maintain that nurse applicants should also be in the upper third of their high school class. I believe that these arbitrary educational requirements often exclude girls who would make excellent nurses. We have evidence to prove that there are many good nurses lacking the academic background now required by training schools. From my experience, I can cite three cases where present-day admission requirements discouraged girls from entering the profession.

A short time ago an acquaintance came to me with a heavy heart. "Edna is engaged," she told me. Her

tone was that of one announcing a death.

"What's the matter—the wrong fellow?" I asked.

"No, Ed is all right, but Edna wanted to be a nurse first. She has been looking forward to that day all her life. You see, my mother was a nurse and both my husband's sister and I are nurses. We all loved nursing. Mother had only a grammar school education and we had only two years of high school, yet we did well in our nursing studies. Now the school won't accept Edna because she hasn't had Latin or chemistry."

Another friend begged me, "Can't you do something? My daughter wants to enter East Side Hospital, but they won't take her because she made only a C average in school."

When I asked one girl what had become of her ambition to become a nurse, she replied, "I wasn't in the upper third of my class so they won't take me at North End Hospital. They will let me in at West End—but that isn't a good school."

This practice of rejecting prospective students solely on their academic record is a fairly common one, and I condemn it as shortsighted and unsound. Once a nurse has her R.N., who is to know or care whether she received an A in her high school course? Certainly not those who are interested in keeping a healthy balance between the supply of nurses and the demand for nursing service.

My class was the last to enter Bellevue when that school required only one year of high school. The student who made the highest grades in our class was not a high school graduate, nor was the one who received the second highest marks. Many of the girls with only one or two years of high school did better or just as well in their studies as those who had completed high school in the upper third of their class. As a head nurse I have found just as many good nurses among those lacking a complete high school education.

I am positive that higher education and good high school grades are not the basic requirements for a good nurse. I venture to say that in some cases higher learning has even been a hindrance. Many girls with the best academic qualifications never become good nurses. They consider themselves above the giving of baths, removing of bedpans and other menial duties of nursing. To be a good nurse, first and always one must have the urge and the love of service. Strong character, mental and physical health should be the chief requirements for entrance to a nursing school.

Today, nearly every girl has a high school diploma by the time she has reached 18 years of age. All the more reason then that special inquiries should be made when the applicant does not have it. A girl, compelled by family circumstances to work instead of finishing high school, should certainly be accepted. Let the doors of nursing schools remain open for the exceptional case.

In our modern methods of nursing education, we tend to push the R.N. away from the bedside into the

charting room. We are letting the practical nurse do the nursing. Too much theory and too little practice of nursing procedures may produce a pseudo-doctor who will be neither an aid nor a comfort to the sick patient. Nursing is a skill that one must learn by doing and not by writing case studies and books.

Not long ago I was a patient. The woman in the bed next to me was extremely uncomfortable because her drawsheet needed changing. When I asked a student to help her, she replied, "I have my charts to do, but if I have time after that I'll take care of it." She did not have time—she had to rush off to class. Before she left she wrote on the patient's chart, "Patient comfortable. No complaints. Dozing most of the morning." I learned that both the supervisor and the head nurse on this service judged their nurses by their well-written charts. Personally, I think that 95 per cent of nurses' chart work could be burned with no loss to anyone. Certainly, one reason for the excellence of the European nurse lies in the fact that she does very little writing but a lot of practical work.

We need instructors and supervisors who have not only high school but a college education as well. However, we are in danger of admitting every student with the idea that she will become an administrator. We must not lose sight of the fact that the large majority of students must be trained to become good bedside nurses. More and more doctors are turning to practical nurses because they like to take care of patients. "Too many R.N.'s feel above bedside nursing," one doctor told me.

The collegiate nursing school is intensifying this trend away from bedside nursing. It attracts the more intellectual girl who in later years as an administrator will neither understand nor be sympathetic toward what I call the "Martha" type of nurse. The "Martha" type of girl should be understood and encouraged; she should be welcomed into nursing. Often these girls will have made just average grades in high school. Yet they will give above-average nursing service once they are given the opportunity. The time is at hand for us to recognize and appreciate the valuable contribution these girls have always made to nursing and would like to continue to give. They are the privates of our nursing army.

Much wiser than measuring the applicant merely by her high school record is the practice of measuring her worth by less tangible means. How is she regarded in her community—in her church? What is her reason for wanting to become a nurse? What is her attitude toward service and toward plain hard work? What is her physical and mental health? Let us study her grades—but let us not forget that the glamor seeker, the world traveler, the air-queen or the brainy scholar may not become the best bedside nurse. Nursing is a rewarding call, and any girl with average grades and the urge to become a nurse should be permitted to find the joys of serving.

HYPERTHYROIDISM

by Frances Lewis, R.N.

THE THYROID, as we know from our anatomy and physiology days, is the gland of internal secretion which controls the rate of cell metabolism and the growth and development of children. Its two winged-shaped lobes are made up of small irregular vesicles or acini filled with colloid or jelly-like secretions of the vesicle lining. The thyroid hormone present in this colloidal protein, thyroglobulin, is released to blood and tissue serum in the form of thyroxine, which contains 65 per cent of iodine by weight. If thyroid secretion is low, hypothyroidism or myxedema occurs, a condition marked by a low basal metabolic rate, sluggish physical and mental activity and stunted growth. An over-generous amount of thyroid secretion leads to hyperthyroidism, the disease with which we are particularly concerned.

Any enlargement of the thyroid, except that caused by malignant growth or inflammation, is called a goiter. A simple, endemic or colloid goiter, resulting from an iodine deficiency in the water and food of inland areas, almost never alters the basal metabolic rate. The diffuse overgrowth in this type of goiter may be caused by the gland's attempt to utilize all of the body's thinly scattered iodine supply for hormone manufacture. Iodized salt, potassium iodide, sodium iodide or iodine solutions will generally either prevent or cure this abnormal enlargement by flattening the hyperplastic cells of the acini and decreasing the gland's vascularity.

An adenomatous goiter is a benign, nodular cellular overgrowth which may or may not produce a toxic condition. It is generally agreed that a goiter of this type with the toxic symptoms of hyperthyroidism, should be surgically excised after a course of antithyroid therapy, in order to avoid the possibility of cancer.

Exophthalmic goiter, also called primary hyperthyroidism, toxic diffuse goiter and Grave's disease after Dr. Robert J. Graves, publisher of a well-known report on the disease in 1835, results in an over-flooding of the body with the thyroid hormone, thyroxine. Thyroxine speeds up food oxidation, liberation of energy and heart action, and whips the nervous system into alternating states of frenzy and fatigue.

Although the typical hyperthyroid patient may have a ravenous appetite, he loses weight because of his inability to adjust his food intake to an abnormally high energy output. Other signs and symptoms of

hyperthyroidism are hand tremors, excessive perspiration, restlessness, irritability, muscle weakness and, occasionally, vomiting and diarrhea. The anterior pituitary rather than the thyroid may be responsible for one of the most striking hyperthyroid signs, that of exophthalmus.

The most common method of diagnosing hyperthyroidism is the basal metabolism test. This test given to the fasting and resting patient determines how much oxygen is absorbed in a certain time. The amount of oxygen utilized is converted into caloric output per square meter of body surface and compared with that of the normal individual of the same biometric measurements. If the rate turns out to be the same, the patient is said to have a zero BMR. Variations above or below average are expressed on a percentage basis; the normal may vary from -15 per cent to +15 per cent. Methods of estimating the BMR may differ but the principle remains the same—the determination of the body's minimum functional activity.

A two-week period of iodine therapy for the hospitalized patient with daily observation of the BMR may confirm the diagnosis of hyperthyroidism. Hyperthyroid patients undergoing this form of therapy will show symptomatic improvement and a progressively lower BMR. Radioactive iodine has also been used as a diagnostic guide. Studies have shown that thyrotoxic patients receiving tracer doses of radioactive iodine—two to six micrograms of sodium iodine—in general, excreted less of the iodine than non-thyrotoxic patients receiving the same dosage.[1] This test should help to diagnose borderline cases where a true BMR cannot be obtained. A Geiger-Muller counter can also pick up the location of thyroid tissue following administration of a tracer dose of radioactive iodine.

Despite rapid progress in the treatment of hyperthyroidism, certain aspects of the disease still puzzle the experts. Although thyroxine has been synthesized, the exact form in which it is secreted in the gland and the way in which it exercises its special effect on the body cells are not yet known. The primary cause of hyperthyroidism itself remains unsolved. More and more evidence suggests that the causative factor lies outside the thyroid—perhaps in the hypothalamus, anterior pituitary, gonads and adrenals or the autonomic nervous system. Irradiation of the pituitary, estrogen therapy, and dessicated thyroid and iodine medication have been used with varying success for patients with pronounced ocular symptoms and mild or absent thyrotoxicosis.[2]

Much emphasis has been placed on the psychosomatic approach to hyperthroidism. The thyroid clinic at Johns Hopkins Hospital utilizes the psychiatrist, internist and social worker in its care of thyrotoxic patients. A study conducted at this hospital and published in the March 12 1949 issue of the *Journal of the American Medical Association* bears

[1] *JAMA*, January 22, 1949, p. 255.
[2] *JAMA*, May 14, 1949, p. 143.

out the contention of many researchers that emotional trauma is the precipitating cause of hyperthyroidism. Almost all of the 15 patients studied had some emotional crisis preceding their onset of illness. Illustrative examples of five patients showed that each patient's difficulty stemmed from the loss or threat of a loss of an extremely important personal relationship.

Although several cases of thyrotoxicosis have been helped by psychiatric therapy, the main treatment in moderate to severe cases is aimed at subduing thyroid activity; that is, trying to cut down the thyroid hormone output in order to effect a satisfactory remission of the disease. Iodine and the official iodide medications which have been employed for some time are still valuable in lowering the BMR and mitigating symptoms but because of their generally temporary effect their value is somewhat limited. Amend's Solution, Burnham Soluble Iodine, Criodin, Di-Iodo-Tyrosine and Iod-Ethamine are some of the proprietary iodine preparations used in the treatment of hyperthyroidism. The antithyroids, Thiourea, Thiouracil and Propylthiouracil have not proved quite as successful as was originally hoped; Methylthiouracil must await further clinical trial. Radioactive iodine while promising much also remains in the experimental clinical stage. Iodine, Thiouracil, Propylthiouracil and radioactive iodine therapy are discussed more fully in this month's *Drug Digest*, p. 38.

Subtotal resection of the thyroid gland continues to be the surest method of obtaining a permanent remission in [*Continued on page* 50]

Probie

"Skip the diagnosis."

T.L.'s for R.N.'s

by Joseph D. Waxberg, M.D.

ON JULY 1, 1948 more than five thousand interns, including myself, began their internship in hospitals throughout the country. The sudden change from medical student to intern presented many problems of responsibility, new routines and adjustment to hospital personnel and patients. There was one member of the hospital personnel, however, who was dependable and courteous and whose knowledge of both doctors' and patients' idiosyncrasies saved many an intern from the embarrassment of error. This answer to an intern's prayer is the nurse, the R.N., who spends her time acting as liaison officer between patient and physician.

The first day of my internship I was assigned to the medical floor. That morning a patient with a coronary thrombosis was admitted. I tried to locate the patient's private physician but was unable to reach him because he was on his way to the hospital. I knew, of course, that the emergency treatment consisted of sedation, oxygen and bedrest, and since the patient needed treatment immediately, I ordered morphine sulfate gr. ¼ stat and oxygen intranasally.

The nurse read my orders and then said very tactfully, "May I make a suggestion, Doctor?"

"Certainly," I answered.

"Dr. T. never uses morphine. He prefers Demerol in these cases. He also prefers the oxygen tent to intranasal oxygen."

It was a mere factual statement, said in a quiet voice with no offense inferred. I accepted her suggestions. After all, I thought, she knew Dr. T., whereas I had not met him as yet. The treatment was the same—sedation and oxygen, but the manner of medication was slightly different. I rewrote my orders.

When Dr. T. arrived, everything was under control. The patient's blood pressure was up and still rising and he had no chest pain.

"You're one of our new interns?" he asked when we entered the chart-room after checking his patient. I introduced myself and he thanked me

for *my* handling of his patient. A wink and smile at the nurse indicated my sincerest thanks for her "suggestions." Before he departed, Dr. T. said that the next time any of his patients came in I was to go ahead and treat them as if they were my own. This indeed was a compliment for a one-day-old intern. Later that day I told this nurse that the R.N. after her name meant "remarkably nice."

I am sure that similar episodes between nurses and interns have been duplicated in many other hospitals. It has never failed during our occasional interns' bull sessions that some particular nurse is thanked *in absentia* for her indispensable aid.

One intern in surgery recalled how Miss J., the scrub nurse on duty, tipped him off before an operation that the surgeon, a well-known prima donna in the operating room, liked to have his bleeders tied with three knots. He also liked to have the ties cut long instead of close to the knot. The result was a smoothly run operation with another commendation for the intern. Later this intern told about the efficiency of these scrub nurses in handing the desired instruments to the surgeon at the right time. He was cognizant, too, that this amazing efficiency was the product of many years of excellent training.

Another example of the nurse's help occurred quite recently on the male medical ward. An intern was notified of the arrival of a new patient with a tentative diagnosis of pneumonia. As he was leaving the chartroom to take the new patient's history and do a physical, the nurse on duty stopped him.

"Here, put this on," she said handing him a gauze mask. "Never take a chance on lung infections until tuberculosis is definitely ruled out. The patient is wearing one, too."

When the laboratory reports returned with a positive finding of tubercle bacilli in the patient's sputum, the intern was indeed thankful for working with a far-sighted nurse.

I personally take my hat off to the nurses who work on the O.B. floor. Women having their first babies are a most apprehensive group. The gentle care and sympathy that an R.N. renders during labor has provoked many a sincere expression of gratitude from the happy mother and father and also the obstetrician. And perhaps of all the nurses on duty, the night supervisor rates highest with the intern. The reason is simple—sleep! Those few precious hours of sleep are guarded by our night supervisor like a lioness over her cubs. All calls for an intern after a certain hour must have her O.K. before they are put through the switchboard. Many a night's sleep has been saved by her knowledge and experience in handling the many questions that arise during the early morning hours. The intern's appreciation is expressed by his prompt answer to her request for assistance.

As this year of internship draws to a close I want to express my thanks for the many ways in which the nurse has helped to make the way less rocky. The R.N. has truly been a friend in need.

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(Iodine Hyperthyroid Therapy)

PROPRIETARY NAMES: Marketed under official name.

PHARMACOLOGY: Strong iodine solution or Lugol's solution, containing 5 per cent iodine dissolved in 10 per cent potassium iodide solution, has long been used for the treatment of goiter. Iodine, a non-metalic element found in sea water and sea weed, is also a normal constituent of the thyroid gland and plays an important part in the formation of the thyroid hormone. Lugol's solution may prevent or cure simple goiter by supplying the necessary amount of iodine to the iodine-starved thyroid gland. It lowers the basal metabolic rate and subdues thyrotoxic symptoms in hyperthyroidism apparently by checking the hormone's release from the thyroid gland. Some authorities prefer to use Lugol's solution with Propylthiouracil for pre-operative thyroidectomy preparation; they believe that it counteracts the vascularity caused by Propylthiouracil and renders the gland easier to excise.

DOSAGE: For preventive purposes daily dosage is 0.06 to 0.8 cc. (1 to 12 minims); for medical treatment dosage may be as high as 3 cc. (45 minims) daily in divided doses before meals for a period of about ten days. At the end of this period surgery is usually indicated, for after this point the patient becomes "iodine fast" and may have a recurrence of thyrotoxic symptoms. A waiting period of two months must elapse before effective dosage can be resumed. Iodine solution should be administered well-diluted—generally in 100 cc. of milk, water or any beverage the patient prefers.

UNTOWARD ACTIONS: "Iodism" may result from iodine overdosage with symptoms of coryza, frontal headache, emaciation, weakness and skin eruptions.

THIOURACIL N.N.R.

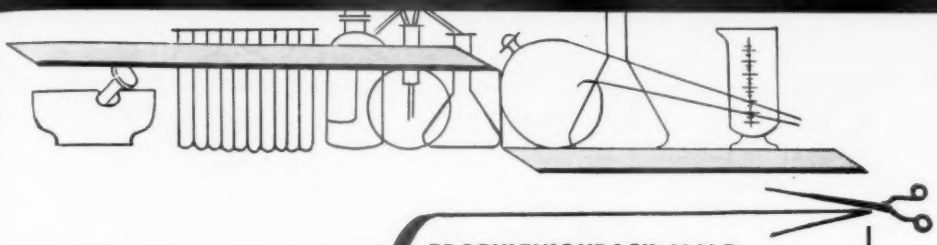
(Antithyroid Therapy)

PROPRIETARY NAMES: Marketed as Thiouracil and Deracil.

PHARMACOLOGY: Thiouracil is the product of the condensation of formyl acetic ester with thiourea, a crystalline compound of urea in which oxygen is replaced by sulfur. In 1943 it was found that Thiouracil significantly lowered the basal metabolic rate in cases of hyperthyroidism. It is now believed that Thiouracil may interfere with the synthesis of the thyroid hormone, thyroxine, from thyroglobulin. It is effective in treatment of diffuse or nodular goiters with accompanying symptoms of hyperthyroidism but has no effect on simple colloid goiters. It may be used either in the pre-operative preparation for thyroidectomy or in the continued control of hyperthyroidism when surgery is not deemed necessary or advisable.

DOSAGE: Thiouracil is supplied in oral tablets, 0.1 Gm. or 0.2 Gm. Daily dosage is usually 0.1 Gm. four times daily before meals and at bedtime. Dosage as high as 0.6 Gm. to 0.8 Gm. daily may be prescribed. Daily maintenance dosage is generally 0.05 Gm. to 0.2 Gm.

UNTOWARD ACTIONS: The patient receiving Thiouracil should be under careful laboratory and clinical observation especially during the first 12 weeks of therapy for recognition of symptoms and signs of leukopenia, agranulocytosis, drug fever and skin eruptions. The Food and Drug Administration decided (February 14, 1946) that the following statement should appear on all containers dispensed to patients: "Warning—This drug may impair resistance to infection. The physician should be consulted at the first sign of sore throat, fever, or any illness during treatment with Thiouracil."



PROPYLTHIOURACIL N.N.R.

(Antithyroid Therapy)

PROPRIETARY NAMES: Marketed as Propylthiouracil.

PHARMACOLOGY: Propylthiouracil, a thiouracil compound, has largely superseded Thiouracil in the treatment of hyperthyroidism because of its greater margin of safety and effectiveness. It is thought to prevent the synthesis of the thyroid hormone, thyroxine. It may be prescribed pre-operatively for the toxic nodular goiter or the toxic diffuse goiter, or for long-term treatment of these goiters when surgery is contra-indicated. After dosage the thyroid generally becomes more vascular and hyperplastic, and the basal metabolism rate falls. After the BMR returns within normal range, the patient may undergo surgery or continue the medication for about nine months or longer. Preliminary study shows that about 50 per cent of the patients who respond to Propylthiouracil have a sustained remission of the disease.

DOSAGE: 25 mg. or 50 mg. tablets are available for oral use. Initial daily dosage is 100 to 200 mg. divided into 50 mg. doses. Optimal dosage should be continued until thyrotoxic symptoms are controlled, followed by a daily maintenance dose ranging from 50 to 75 mg. daily. Patients with toxic adenomatous goiter or those who have received iodine therapy will probably not receive full effects of dosage for 30 to 60 days.

UNTOWARD ACTIONS: Although toxic reactions are less frequent than with Thiouracil, agranulocytosis, leukopenia, drug fever and skin eruptions may occur. Sore throat, fever, rashes, gastro-intestinal disturbances, joint pains and malaise should be reported. Containers of Propylthiouracil must bear the same warning label as those of Thiouracil.

RADIOACTIVE IODINE

(Radioactive Therapy)

PROPRIETARY NAMES: No proprietary products available. Principal source of supply is the Atomic Energy Commission.

PHARMACOLOGY: Radioactive iodine, made radioactive in an atomic pile or cyclotron, is valuable as a diagnostic and therapeutic agent in toxic diffuse goiter and may cause partial contraction of nodular goiters. If no therapy has been given recently (iodine and Thiouracil medication should be stopped four weeks and one week respectively before treatment), the enlarged gland may take up to 40 per cent of an oral dose of radioactive iodine. The gamma rays and beta particles emitted by this dosage may reduce thyroid over-activity in a period of one week to six months or even longer. There has been about a 70 to 80 per cent remission in selected cases.

DOSAGE: The patient swallows a few millicuries of the iodine in a liquid. (A millicurie is one-thousandth of a curie—a unit of radioactivity.) Although there are several forms of radioactive iodine, the one generally used in medicine is I^{131} with a half-life of eight days, which means that it loses one-half of its radioactivity in eight days, one-half the remainder in eight more days, etc.; 131 refers to a number of particles in the iodine nucleus.

UNTOWARD ACTIONS: Since radioactivity is not easily controlled, excessive destruction of tissue may cause aggravated ocular symptoms and produce myxedema or hypothyroidism. There may also be a possibility of a carcinogenic effect on the thyroid and damage to the urinary tract, although this has not been proved. All persons handling the substance must be protected by lead-impregnated clothing.

FOREWORD: In the past, the economic winds have blown harshly on the private duty nurse. And although calls for her services today are almost breathtakingly frequent, she can't help wondering what the see-saw of supply and demand will do next. Will both ends balance or will patient demand let her down hard? Her apprehension is increased not solely by economic factors, but also by the changing concept of nursing itself.

According to the latest studies made of the nursing profession, the private duty nurse is left out on the doorstep. Dr. Esther Lucile Brown in *Nursing for the Future* stresses more definite delineation of practical nursing duties and professional nursing duties, and hints that eventually there may be no place for the bedside nurse with a three-year diploma. Dr. Eli Ginzberg, speaking for the Committee on the Function of Nursing in *A Program for the Nursing Profession*, is even more specific. He states that due to the increasing number of prepayment plans and the better staffing of hospitals, "before long private duty

nursing will be deemed a luxury available only to the very well-to-do . . . "

How is the private duty nurse taking these predictions of her future? Not lying down. There is evidence that private duty nurses are becoming more and more conscious of the value of organizations. They are banding together not only in common defense but also to set their own house in order and adopt new policies in line with the changing times. At the recent meeting of the ANA Private Duty Nurses Section, private duty nurses learned of their potential role in prepayment insurance plans, the development of better professional counseling and placement services and other matters concerning their own welfare and that of the patient.

Sophia Cornelison in her article on private duty nursing exemplifies the spirit of constructive criticism from within the ranks. She isn't satisfied with the present situation of private duty but believes something can be done about it. While readers may not agree with everything that Mrs. Cornelison says, they will sense her willingness to move with the times and also her determination to hold fast to the tried and true traditions of "private duty—bedside nursing in its highest form."—THE EDITORS

* * *

I SHOULD LIKE to have private duty nursing made more attractive to the young, efficient nurse because I believe that private duty—bedside nursing in its highest form—is an indispensable part of hospital care.

However, private duty today is in a chaotic state due to different types of nurses, inefficient handling of cases, varying standards of hospital care and inconvenient working hours.

To my knowledge, the educational departments of hospitals have not provided in-service training for private duty nurses so planned and publicized that they can arrange to attend; nor have I seen private duty standards and policies set forth in our professional magazines.

PRIVATE DUTY NURSES for the most part are in the older age group. Many nurse as a stop gap measure or because of economic need. The majority do not subscribe to the *American Journal of Nursing*. The private duty section of the district association is not stimulating nor well attended. Yet the cases for which these nurses are called demand the highest type of nursing skill, as you can judge from the following cases for which I was called to 12 different floors in six different hospitals. These cases required adjustment to the wishes of hospital personnel, the patient, his family, and a knowledge of the layout and routines of six varied hospitals.

How can one possibly know the techniques of good nursing care for all these cases without constant study or actual experience? Would you want me to special your sister, a caesarian diabetic primipara, if you knew that I had not been near an obstetrical floor since 1937 nor cared for a diabetic since 1922? Well, I wouldn't normally, but there was no other nurse on call so I went on the

case. The registry simply said that it was a surgical case. I have thought of refusing certain hospitals and types of cases but I do not think that is right. Needless to say, I do not have time to look up procedures while on an unfamiliar case.

THE STAFF NURSES and head nurses have been wonderful, as a rule, in trying to orient me but I know that they have a multitude of other duties. After all, I am paid $10 a day and should know what to do and where to go for supplies without constantly asking them questions.

There was a time when the hospital could rely on the skill and integrity of the special nurse, especially during the 24- and 12-hour working day. But with three nurses on each case, I think that this is no longer possible. Because many nurses are using private duty more as an interim job rather than an opportunity for skillful nursing, a certain amount of hospital supervision is necessary in order to protect the patient.

Once I reported through the head nurse to the supervisor that the 7 to 3 nurse did not start a proctoclysis ordered at 10 A.M. for a critical dehydrated patient. The 7 to 3 nurse gave as her excuse, "You do not have anything to do from 3 to 11." I was told by the director of nursing that I should have reported directly to the doctor because a private duty case is out of the hands of the hospital. To whom the private duty nurse is responsible in all the different hospitals is something which I think needs to be clarified.

On the case already mentioned and on another case in a different hospital, there was not one visit made by the supervisor or head nurse unless I especially requested advice or asked for supplies. I hasten to add these were always promptly and graciously given. The policy of these hospitals is "the care of the patient comes first and always." This is carried out meticulously by the staff nurses for the patients on general care, but I doubt if the hospital would always approve of what sometimes goes on behind closed doors.

I would not for a minute have you believe that I think private duty nurses deliberately neglect their patients, but I am troubled very much by the apparent lack of interest in private duty nursing on the part of hospital management.

IF THE NURSE does not give satisfaction to the patient, the patient or the family requests another nurse. The nurse usually does not know why she has been taken off the case; consequently, she has no guide for future improvement. She continues to go on call and the public unfortunately judges nursing by her standards of care. Good public relations may require good public speakers, as so interestingly stated by Mark Hanna in the *American Journal of Nursing* [March 1948], but I believe that good nursing public relations also requires good nursing care and adjustment to personalities.

Neither the hospital nor the professional registry where I receive my

cases keeps an extensive efficiency record of my work. It seems to me that they should have an efficiency record somewhat on this order:

1. Age group
2. Education
3. Civic, social and professional activity
4. For what type cases best suited
5. Working relationship with hospital personnel
6. Working relationship with doctors, other nurses on case, family and patient
7. Subscribes to professional magazines or does not.
8. Has attended the following procedure demonstrations, classes, workships.
9. Is familiar with standing orders of physician for her cases.
10. Is familiar with the hospital orientation form for private duty nurses regarding where to get supplies, location of departments, charting.
11. Appearance—Wouldn't it be important to know if she came on duty with shoes, cap and uniform soiled or immaculate, or whether her hair was straggly or neatly kept?

I am endeavoring to work the 40-hour week and earn a salary commensurate with that of the staff nurse. But you will notice in the chart that the number of days on each case were in this order—5, 2, 2, 2, 2, 3, 2, 8, 3, 16, 8, 1, 1, 5, 11, 1, 21. This irregularity of working leaves no way I can plan for a social program, take civic responsibility with regularity, have regular periods of rest, or plan regular attendance at classes or professional meetings. I have tried to arrange to go on call so that I can be off the third and fourth Thursday of the month but this is just something to dream about. Invariably I am on a case on those days. However, social life is not as important to me as to the young nurse. How old am I? Fifty-two.

	Diagnosis	*Hospital*	*Days on case*
1.	Hysterectomy-embolism	Maynard	5
2.	Blood transfusion reaction	Providence	2
3.	Old colostomy-cancer	Maynard	2
4.	Industrial dermatitis	Virginia Mason	2
5.	Oophorectomy-phlebitis-bilateral salpingectomy	Virginia Mason	2
6.	Stroke-total deafness	Virginia Mason	3
7.	Sigmoid-perineal resection-old cancer	Virginia Mason	2
8.	Hodgkin's disease	Doctor's Hospital	8
9.	Hysterectomy	Maynard	3
10.	Enlargement of heart—Staph. blood infection (8-year-old girl)	Seattle General	16
11.	Ruptured appendix-peritonitis (5-year-old boy)	Seattle General	8
12.	Glaucoma (surgical)	Virginia Mason	1
13.	Caesarian-diabetes-(primipara)	Virginia Mason	1
14.	Ruptured peptic ulcer	Seattle General	5
15.	Mastectomy-cancer	Swedish	11
16.	Asthma—in for observation and tests	Seattle General	1
17.	Pneumonia	Swedish	21

The young nurse is not interested in private duty; the hours are too irregular. Also she does not care for cases which, after the emergency nursing period is over, consist of being a companion to patients who, from the doctor's standpoint, do not need special care. She believes she is wasting her talent on chronic cases. On one of my "luxury" cases I overheard the patient say over her private phone, [*Continued on page* 62]

REVIEWING THE NEWS

▶ STEALING THE TUNE from Connecticut which follows the "hair of the dog" principle by earmarking 9 per cent of its liquor taxes for treatment of alcoholism, the National Committee for Education on Alcoholism has optimistically placed donation cans in the bars and saloons of New York City. A spot-check showed that barkeepers were all in favor of the collection; it remained to see what view—dim or otherwise—their customers would take of it. This is one of the features of the Committee's drive to promote the creation of a chapter in New York—a city which has about 40,000 acute alcoholics, according to Mrs. Marty Mann, executive director of NCEA.

▶ INCREASED WAGES, amounting to $10 a month, have been promised 50,000 British nurses, many of whom have been receiving only the equivalent of 28 cents an hour—or less than half the hourly rate of a London charwoman. Shortly before the pay boosts were announced, a thousand or more nurses staged a mass demonstration in London's Hyde Park, after parading in uniform through the streets with banners demanding "a living wage."

▶ A $500 AWARD from the Mental Health Foundation and the Catherwood-Kirkbride Fund for Research in Psychiatry goes to Roland J. Brand, an attendant at the Milwaukee County Asylum, Milwaukee, Wis., who successfully discontinued the practice of restraining disturbed patients on his ward.

▶ INDIAN VICTIMS of the severe blizzards in the west and southwest areas were aided by Red Cross emergency staffing of reservation hospitals and provision of direly-needed food and medical supplies.

▶ GOP OMNIBUS BILL, S. 1970, avoids the bureaucratic, compulsory features of the Administration's health bill, S.1679, and the "means test" of the Taft bill, S. 1581. Instead, it would give benefits to almost all income groups by adjusting the premiums of voluntary health insurance plans to individual incomes. Coverage of the plans would be measured by a national standard and the cost of such coverage in a certain region determined by a special regional committee. Difference between cost of coverage and premium revenues would be met by Federal funds. The program, headed by the Surgeon General of the USPHS, aided by a Federal Health Council, would include state councils and the aforementioned regional committees; physicians and dentists could be advisers but not members of these councils and local groups. In common with S. 1679, the Re-

publican bill also provides for Federal grants to medical and nursing education, hospital construction and public health units.

▶ CANADIAN NURSES were told by Toronto's Mayor McCallum to nurse in Canada, when he spoke at the 67th graduation exercises of Toronto General Hospital School for Nurses. He disclosed that emigration by Canadian nurses in 1948 exceeded that of 1947 by 81 per cent—the highest emigration rate of any professional category.

▶ NEWSLINGS: Student nurses of Mount Sinai Hospital, N.Y.C. have "adopted" an eight-year old Italian girl through the Foster Parent's Plan for War Children . . . New Jersey State Department of Institutions and Agencies will soon open a unique type of diagnostic center, designed to examine, rehabilitate, or commit lawbreakers and maladjusted persons to the appropriate institutions . . . Syrup of Urethane, cough medicine, has been pronounced unsafe by the Federal Food and Drug Administration and called out of circulation . . . New York City has a ratio of 447 residents to one doctor; Chicago, 475:1; Philadelphia, 445:1; Detroit, 594:1; Los Angeles, 446:1; Baltimore, 420:1; St. Louis, 402:1; and Boston, 263:1. The national ratio is 729:1 . . . The Tarrytown Hospital, N.Y., campaigning via newspaper for funds to purchase a television set for the nurses' home, in a week's time received $810.34, or twice the needed amount . . . Almost 50 per cent of all nurses have responded to the ANA questionnaire sent out at the request of the National Security Resources Board to determine existing and potential U.S. nursing resources . . . 12 N.J. nurses have won scholarships granted by National Society for Crippled Children and Adults for orthopedic nursing course at Seton Hall College . . . Federal Food and Drug Administration is cracking down on illegitimate drug store sales of sleeping pills and sulfa drugs without prescriptions . . . The American Legion's national rehabilitation conference recommended that VA hospitals employ nurses over 40 even if they can't meet educational qualifications [*Continued on page* 54]

▼ Mary M. Roberts, editor emeritus of the "American Journal of Nursing," who recently received the Mary Adelaide Nutting Award at the NLNE convention in Cleveland, is presented the Army Certificate of Appreciation by Maj. Gen. Raymond W. Bliss, Army Surgeon General.

National Military Establishment

Wallace Litwin

THE NEW LOOK via SURGERY

by Dorothy Allen Barash, R.N.

PERSONS WITH STRABISMUS or eye muscle imbalance deserve ophthalmological care for their mental as well as their physical well-being. If their defect goes uncorrected, they are apt to shy away from contact with other people and develop a warped and introverted personality. Children, perhaps, suffer more than adults in this respect. They desperately want to be like other people.

Lois J., an attractive child about 11 years old, was brought to the doctor's office for an eye examination. She kept her head down and shuffled rather than walked. "Please, mother," she begged, "I'm tired of doctors. Let me wait outside." The mother revealed that Lois, who had been cross-eyed from birth, was very self-

conscious and always kept to herself. Mrs. J., an intelligent woman, had encouraged the child to participate in activities that might compensate for her handicap. There had been piano lessons, dancing lessons and great stress laid on personal appearance. However, the little girl still shrank from social contact.

Children like Lois will benefit merely from the cosmetic result of an operation for muscle imbalance. And the earlier the operation is performed, the better will be their chances of permanent cure and the better their chances of leading a normal happy life.

The two most obvious types of muscle imbalance, from the cosmetic standpoint, are the convergent squint (cross-eye) and the divergent squint (wall-eye). Another kind of eye muscle imbalance, called phoria or latent muscle imbalance, cannot be easily detected. In this case, the patient is able to keep the eyes straight though their natural tendency is to turn either in or out. The effort of holding the eyes in a straight position is sometimes so difficult that it results in severe eyestrain or headaches. This condition, like the other two, may be amenable to surgery.

Results from surgical treatment of these conditions can be grouped into two categories: functional and cosmetic. When a good functional result is obtained, the eyes not only become normally centered but they actually work together again. This type of result is almost always permanent. On the other hand, achievement of a cosmetic result alone may be associated with reduced vision in one eye. The eyes appear straight but do not function normally.

The ophthalmologist studies each case of muscle imbalance carefully before he decides to operate. After dilation with atropine, the eyes are examined to determine whether the patient is far-sighted. If a far-sighted condition is present, it must be fully corrected with proper strength glasses before surgery is considered. A fairly large number of cases can be straightened by the use of glasses alone. If the vision in the squinting eye is reduced (amblyopia), the straight eye may be covered (occlusion) to put the visual load on the poor eye. If the child is under the age of five, occlusion often serves to restore the vision in the squinting eye. For this reason, the earlier the patient is seen by the ophthalmologist, the less extensive will be the corrective treatment.

After determining visual acuity, the degree of ocular deviation is carefully measured. This measurement is essential for gauging the amount of shortening or lengthening to be done to the muscles during surgery. A record of the deviation must be kept so that it can be compared before and after the first and second stages of the operation. In this way the surgeon will know the exact result of the operative procedure.

The operation itself, usually performed under sodium pentothal anesthesia, consists of changing the deviated position of one eye by the simple expedient of lengthening one muscle and [*Continued on page* 49]

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The New Look

[*Continued from page* 47]

shortening the other muscle. In the case of a person with crossed eyes or convergent squint, the inside muscles of the eye, the internal recti, exert more effect than the external recti and therefore draw the eyes toward the nose. These muscles must therefore be respectively lengthened and shortened so that the eyes will line up correctly.

The internal rectus muscle is set back on the eyeball a determined number of millimeters and then reattached to the eye with interrupted 4-0 chromic sutures. This method of lengthening tends to weaken the muscle which had previously been too strong. Following this procedure, the external rectus muscle is moved forward or shortened by excising a small piece of the muscle tendon. The shortened muscle is sewed to the eyeball in its new forward position with interrupted 4-0 chromic sutures. Eye muscles are not generally shortened or lengthened in excess of five or six millimeters. During operation, measurements are made with small calipers and a millimeter scale.

After two or three months when all reaction has subsided and the sclera of the operative eye is again white, measurements are taken to see how much effect has been obtained. If the condition is still under-corrected, further surgery of a similar nature is planned on the other eye.

The patient is pleasantly surprised to find that there is little or no pain postoperatively. Unlike the cataract patient, he is not kept completely immobilized, but because both eyes are bandaged for the first few days, movement is necessarily restricted, and complete nursing care must be provided. After two or three days, the bandage from the unoperated eye is removed and he is allowed to be up and about his room. He is discharged following the removal of the second bandage, usually on the fifth or sixth day.

Nursing of children who have undergone an operation of this type will pose special problems. The child is usually restless and must be watched closely to see that he doesn't pull off his bandage and touch the operative site. Reading aloud, playing guessing games or providing him with a radio will help to while away the tedious hours. Reassurance is needed by both young and old. One thing is usually uppermost in their minds—"Was the operation a success? Will my eye really be straight now?"

As in the case of our patient Lois J., most of these eye imbalances are congenital and have some basic deficiency in their fusion faculty. This is a phase of eye work in which considerable progress, especially from a surgical angle, has been made in the past decade, with promise of continued advancement.

When the result is successful—and it generally is—it is gratifying to see the expression on the patient's face as he looks into the mirror for the first time following operation. The surgeon has given him a new look as well as a new outlook on life!

Mich.

Hyperthyroidism

[*Continued from page* 35]

a majority of unselected cases. Surgery is only contra-indicated for bad-risk patients such as children, those with bad heart conditions and post-operative recurrences. Thanks to better pre-operative and postoperative management, thyroid surgery has lost many of its dangers in the past few years.

The main objective of pre-operative preparation is to bring the BMR within normal limits. This is usually accomplished by iodine and Propylthiouracil therapy, and supportive measures in which the nurse plays an important role. Food intake, in order to exceed energy requirements, generally consists of 3,000 to 5,000 calories a day, with protein making up 25 to 35 per cent of the caloric intake. Vitamin B medication is indicated and the fluid intake should be increased. Mild sedation is given to help reduce the eccentrically fast pulse rate by maintaining the patient in a less excitable state. Hyperthyroid patients should be kept physically comfortable at all times. Because of their sensitivity to heat it is necessary to check room temperatures frequently; a sheet and spread usually provide sufficient covering. Sources of infection shou'd be guarded against by isolating these patients in either a separate ward or room.

Ideally, the hyperthyroid patient should have no worries. However, a regime of bed rest alone will not set his mind at rest. The nurse be-

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cause of her close patient contact can ferret out the sources of discontent and report these to the doctor or social worker. Since these patients are apt to imagine all kinds of disasters happening to their family and home, it is wise to relax visiting hours so that they can keep in close touch with their families. The nurse will find that hyperthyroid patients are frequently difficult to get along with; they may ring the call-bell just to assure themselves that someone is within reach. Remember that anxiety and irritability are symptoms of their disease and that even the most trivial worries should be given generous consideration.

The optimal time for operation arrives when the BMR is normal and the patient shows a distinct symptomatic improvement. "Stealing the thyroid," a method first suggested by Dr. George W. Crile to offset anticipatory dread of surgery, is still used in many hospitals for particularly nervous patients. Pentothal sodium is administered intravenously to the unsuspecting patient who believes the procedure to be just one of the many hospital tests. Either inhalation or local anesthesia may be used in the operating room depending on the surgeon's choice. Pre-operative tracheal intubation helps to ward off the danger of anoxia, a dreaded complication of thyroid surgery.

Some of the complications of surgery such as thyroid crisis or thyroid storm have been largely eliminated by better control of anesthesia. If crisis does occur with attendant symptoms of tachycardia, fever, and anxiety, treatment may consist of blood transfusions, intravenous dextrose and iodine injections, sedation, vitamin B medication and oxygen.

Damage to the parathyroids which lie on the lateral poles of the thyroid may be one of the mishaps occurring in surgery. Symptoms of damage to these glands are those of tetany: twitching of muscles, nervousness and paresthesias of the face. Traumatic injury to the recurrent laryngeal nerve can cause dysfunction of the vocal cord. Fortunately, these complications are relatively few. A recent report on 655 patients who underwent thyroidectomy during a 10-year period prior to 1947 shows that this operative procedure carries a mortality rate of less than 1 per cent and less than 4 per cent risk of recurrence.* It should be remembered, however, that frequently symptoms such as vasomotor instability and exophthalmus may persist after operation. Surgery does not release the patient from regular medical supervision.

The nurse who cared for thyroidectomy patients several years ago will not cease to be amazed that most of these postoperative patients are able to leave the hospital within a few days. The night nurse who dreaded the postoperative thyroidectomy patient will be one of the first to acknowledge and appreciate the advances made in the treatment of hyperthyroidism.

*JAMA, May 14, 1949, p. 145.

[Bibliography available upon request.—THE EDITORS]

News

[*Continued from page* 45]

. . . Berniece Sollman, of Indiana, has received the first of the Linda Richards state medals.

▶ 30,000 PRACTICAL NURSES a year is the goal of Oscar Ewing. The Federal Security Administrator, addressing the eighth annual conference of the National Association for Practical Nurse Education, stated that if President Truman's compulsory health insurance program is approved, the number of trained practical nurses will increase from 2,000 to 10,000 and eventually reach the 30,000 mark.

▶ NURSING CONSULTANT positions paying salaries ranging from $4,479 to $7,432 a year are being offered by the U.S. Civil Service Commission without written examination in the fields of public health, maternity, orthopedics, pediatrics and psychiatry. Appointees may be assigned to Washington, D.C., regional offices of Federal agencies or various communities. Applicants must be currently registered as graduate professional nurses and have had specialized experience pertinent to the type of nursing consultant position for which they are applying. Age limits, waived for persons entitled to veteran preference, are from 18 to 62. Further information and application forms may be obtained at most post offices, Civil Service regional offices, or by writing to the U.S. Civil Service Commission, Washington 25, D.C.

▶ REFUGEE PHYSICIANS are going to find it easier to enter this country. The Displaced Persons Commission has liberalized its regulations and now voluntary and public agencies can sponsor licensed D.P. doctors without specifying their future residence or place of employment.

▶ JULY PUBLICATION of the official report of the National Health Assembly, held in Washington in May 1948, has been announced by Harper & Brothers. The book, called *America's Health: A Report to the Nation*, with an introduction by Oscar R. Ewing, will include a digest

of the Assembly's debate and findings on medical care problems, and reports from each of the 14 key sections of the Assembly.

▶ ABOUT PEOPLE: *Dean Margaret Bridgman,* on leave from Skidmore College, has accepted a temporary two-year appointment with the Russell Sage Foundation as special consultant to advise universities, desirous of opening collegiate schools of nursing, on the problems of procuring faculty and setting up and financing professional nursing programs . . . From the VA comes word that *Minnie E. Pohe,* former USPHS consultant in nursing education, has been named assistant chief of the VA Education and Training Division in charge of the graduate nurse education program; *Mrs. Ruth Boyer Scott,* a well-known nurse writer, has been appointed to the VA Professional Standards Division; and the following nurses have been designated as chiefs of nursing service: *Isabelle M. Maffette,* at the VA hospital in Castle Point, N.Y.; *Marion E. Thuma,* at Fort Howard, Md.; *Martha T. Knutson,* at Sioux Falls, S.D.; *Clara Bouwhuis,* at Houston, Tex.; and *Margaret L. Greene* at Portland, Ore. . . . *Lucile Petry,* Chief of the Division of Nursing of the USPHS, last month was appointed to the office of Assistant Surgeon General of the Public Health Service, Federal Security Administration, the first woman to hold this position . . . The AMA has announced that "plans have been formulated for the retirement of *Dr. Morris Fishbein,*" for 37 years editor of the *Journal of the American Medical Association . . . Mrs. Anita Keller Henson,* a graduate of the Provident Hospital School of Nursing, has been appointed the first Negro supervisor of public health nurses in Baltimore, Md. . . . *Alta Elizabeth Dines,* retired Director of the Department of Educational Nursing of the Community Service Society, and *Mary M. Roberts,* editor emeritus of the *American Journal of Nursing,* were both awarded the Florence Nightingale Medal for "distinguished service and great devotion to the sick and wounded in time of war and in time of peace," at the national convention of the American Red Cross held at Atlantic City, June 27-30.

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R.N. Speaks

[*Continued from page* 25]

tions, with his little preparation, supervising a surgery and other corpsmen, I couldn't help but criticize the backwardness of a system that could be so shortsighted as to permit this to take place.

At this particular phase of the war if the Army had had the foresight to recognize the value of men nurses in the Service and commission them in this branch of Service, where they were so direly needed, there might have been one chance in a hundred that a commissioned male nurse would have been available for assignments such as this. While I debated whether Johnny could handle a job as big as that he was asked to undertake, I wasn't mainly concerned about him; I was thinking of the patients that would pass through that surgery and was thinking of past experiences. By that time I'd lost count of the number of corpsmen I'd helped train, both in the U.S. and overseas, but I hadn't forgotten the innumerable verbal reprimands my conscience forced me to give various surgeons who unthinkingly or intentionally put too much responsibility on these partially-trained corpsmen. As soon as the technician could execute the basic operative procedures with a minimum amount of nursing skill, we would find a few of our doctors encouraging him to undertake tasks far beyond his training or capabilities. When the risks became too great, and as it was usually impossible to change the surgeon, the corpsman was banished from the O.R. regardless of how valuable he was, until he realized his limitations.

Under combat conditions it was more difficult to guard against such instances, especially when we all realized that at times if the procedure wasn't done by a partially-trained technician it might not be done at all.

During this last war, many of us saw corpsmen with a minimum of training give I.V. pentothal sodium. With the overworked surgeon and scrub nurse fighting for the patient's life, it was often a question of the corpsman giving the anesthesia or no anesthesia at all.

In the early months of 1943 Johnny was sent to New Guinea to do a male nurse's job, with one twenty-sixth as much training. In that same year the Surgeon General of the Army said, "It would be impracticable to employ male nurses in time of peace since such employment could complicate unnecessarily the administrative problems." During the war the Army talked of the impracticability of peacetime commissions. In peacetime, 1948, the Deputy Surgeon General of the Army [**R.N.**, Nov., pp. 13-14] referred to the incongruity of a commissioned male officer engaging in nursing duties. Why incongruous? What if Johnny had been a commissioned male nurse instead of an enlisted man with a little nursing training, do you think the attitude of his patients would have been any different? Do you think his officer rank would have lost prestige because of the kind of nurs-

ing services that he had to perform?

I know if I could speak for all of us who trained the "Johnnys" for their various jobs in this past war, I'd say we admired and marvelled at the job they did, but we knew their limitations. The hours we spent training them were hours that could have been used giving nursing care to patients who needed it. If we had had all the female nurses in the profession, there were still instances when female nurses were useless—such times as when casualties were in inaccessible parts of Guadalcanal, New Guinea, New Britain and the Philippines, where female Army and Navy nurses weren't allowed.

Four months ago a conference of representatives of the Army, Navy and Air Force was held in Washington "at which time it was agreed that the present Surgeons General of the Armed Forces recognize that the utilization of qualified male nurses in the National Military Establishment is possible. However, no provision of law currently exists which authorizes the commissioning of male members of the nursing profession as such in the Armed Forces."

What progress has there been in their thinking? Last year, when Brig. General Armstrong was alienating nurses with his statements already referred to, he also said "Considering the administrative difficulties of commissioning such personnel [men nurses] in a Corps designated as female only, it has been deemed inadvisable to request any change in the law at the present time."

Maybe we shouldn't ask, but would it be such a gigantic task to revise the Army-Navy Nurse Act of 1947 to include the commissioning of men nurses?

True, men nurses only compose about 3 per cent of the nursing profession and it's unthinkable that anywhere near that number would be interested in commissions in the Army or Navy Nurse Corps, but that small number interested is an integral part of the nursing profession. Why should they be discriminated against by existing legislation?

The housing problem that would be created is the thinnest argument so far advanced. And as for the concern over restricting men nurses to male wards—this would be humorous

if not so serious. So far as we know the Army and Navy are still made up of predominantly male personnel.

Faced with the known facts and chancing a guess at the unknown, it appears, as this editorial is being written, that the Army is less opposed to the idea of commissioning men nurses than is the Navy. But, how to do it appears to be its Armageddon. Whether men nurses should be commissioned in the Medical Corps of the Army of the U.S. or the Army Nurse Corps poses one problem. What should be their ratio to female nurses is another. How high in rank should they be allowed to go is another. (I wonder if there has been any speculation on the possibility of a man superintendent of the Army Nurse Corps?)

The Navy, although suffering from the shortage of qualified medical personnel, is satisfied with the status quo. To quote from a recent letter of a Navy spokesman: " . . . it is believed that with the Navy Nurse Corps, as presently established, along with the trained Hospital Corpsmen and the Hospital Corpsmen under training, the quality of the nursing service available in the Navy will meet all the essential requirements." The door isn't even slightly ajar.

And what of the other Government services—what attitudes prevail there?

Prior to July 1, 1948, the Public Health Service (USPHS) employed men nurses on Civil Service status in its hospitals for many years, but a year ago the regulations which precluded the commissioning of men nurses were omitted. Men nurses who meet the other qualifications for the Commissioned Corps of the Public Health Services have an open door before them.

From the VA comes the information "that the opportunities for professional growth, advancement and personal satisfaction in a position are limited to the man nurse by his own vision, desire for development and interest in his work. The man nurse, as is the woman nurse, is appointed to grade on the basis of qualifications, experience and advanced preparation." The VA does not restrict the appointment of men nurses by any quota system. With approxi-

mately over 1,000 men nurses on duty in 127 VA hospitals, there still is room for more.

Men nurses, as well as women, are eligible to compete in Civil Service examinations, if qualified. The following agencies that employ men nurses and frequently request certificates of eligible nurses from the Civil Service Commission are: St. Elizabeth's Hospital, a large Federal psychiatric hospital located in the District of Columbia, which has an accredited school of nursing admitting male students; the USPHS and the Panama Canal Service. In the Panama Canal Service, men are employed to fill positions in areas where it is inadvisable to assign female nurses.

Freedmen's Hospital, a hospital for Negro patients, located in the District of Columbia, has not employed any male nurses, but it is understood this hospital is willing to in certain types of services.

Gallinger Municipal Hospital, administered by the District of Columbia Health Department, occasionally employs male nurses.

The Indian Service does not employ men nurses, not because it does not fully appreciate the value rendered by men nurses, but because the Indian Service hospitals have a larger woman daily patient average than man. Furthermore, the obstetrical service in the general hospitals is quite active, as is the pediatric service, and there are no living quarters available for men. Miss Sallie Jeffries, the Director of Nursing of the Bureau of Indian Affairs, wrote that

"Should there be future developments to offset some of these factors, the situation would change."

Many of the Government services have seen the light, but it is readily seen that more education should be directed to others.

That the term "nurse" became synonymous with the female of the species is unfortunate, but many think it was not accidental.

Traditionally a profession for men, developed under the monastic system, it is said that the interest of men in nursing was already on the wane when Florence Nightingale appeared on the scene, organized nursing and discouraged men in nursing by emphasizing it as a profession for women. Consequently, perhaps by accident, perhaps by design, the pendulum swung to the opposite side. Now the time has approached when both men and women can share the profession in harmony.

But while that pendulum still shows an inclination for agitation, and while men nurses remain a 3 per cent minority, a good adage for them to remember is, "The wheel that squeaks loudest gets the grease."

—Alice R. Clarke, R.N.

Interestingly enough, history records that there was once a prejudice against a woman as a nurse—except in some "uncivilized" countries. The Roman Emperor Hadrian in A.D. 124 outlawed women nurses as tending to "reduce the morals" of male patients. But he didn't outlaw male nurses for women.

Private Duty

[*Continued from page* 43]

"My nurse just loves to rub my back. She does it by the hour."

My suggestion is that the physician should write his order for "emergency nursing care around the clock" to continue for as many days as necessary just as he would order a blood transfusion.

The hospital would hire "emergency nurses" on a monthly basis as part of the hospital staff so that days off would be planned as for the staff nurse. Probably part-time, efficient married nurses could work as relief —let's say four days a week to relieve two nurses. That is, one part-time nurse would relieve two nurses on the morning shift, one would relieve the afternoon shift and another would relieve the evening shift. Perhaps relief float nurses for each shift would work out better for the two days the nurse is off each week, or perhaps the registry could work out some system whereby the same nurses would be nursing in one hospital over a period of time and would have regular days off each week.

This nursing would be for emergency care only. For those patients desiring luxury or chronic nursing, the older nurse would be suitable. And when I say older, I mean old in the sense that she has not kept up with new nursing trends, her physical strength is below par and she is old in her ability to adjust to situations and personalities with ease and grace.

The registry would classify its nurses as emergency, luxury and chronic. The patient would then be considered as any other patient on general care under the supervision of the head nurse, and the private duty emergency nurse would be on a par with the staff nurse.

I would like to see the ANA, the NLNE, the hospital, the registry, and nurses—both staff and private duty —work together to provide educational and on the job opportunities for improvement of special bedside nursing care.

To keep a patient cool in the summer let an electric fan blow over a cake of ice, but be careful that a direct draft does not blow on the patient.

The Alexian Brothers

[*Continued from page* 29]

obtain a bachelor's degree. In addition, an affiliation in neuro-psychiatry is offered outside the home school. Much the same plan is in operation in the St. Louis school, where an affiliation is maintained with St. Louis University. The St. Louis school is accredited by the Missouri state board.

Both schools admit laymen regardless of their religious affiliation provided they meet admission requirements common to all schools of nursing. The Brothers who enter the schools of nursing have already spent a six-month probationary period at the Postulate at Signal Mountain, Tennessee, and a two-year novitiate at Glennondale in Clayton, Missouri, at the end of which time they make solemn religious profession of the simple vows of poverty, chastity and obedience.

The Brothers who graduate from the nursing schools may be sent to any of the Alexian Brothers hospitals or to the home for convalescents. Lay graduates find numerous opportunities in all the hospitals which employ men nurses, including those that are operated by the Veterans Administration.

The young men who study in the Alexian Brothers schools are following a pattern created in the days when the Black Plague was sweeping across the face of Europe. At that time a group of charitable laymen banded together to care for the afflicted and bury the dead. Gradually, under the direction of Brother Tobias ver Hooven, they added the duty of common prayer and thus took the first steps toward becoming a religious Order. After recognition by the Pope, the society adopted St. Alexius Savelli as their patron saint. Surviving the turbulent days of the French Revolution, the group re-organized as a Congregation in the middle of the nineteenth century and had soon established foundations in Belgium, England, Germany, Ireland, Switzerland and the United States.

The first American community of Alexian Brothers was established by Brother Bonaventure in Chicago. Today, a 275-bed general hospital, the

largest privately owned hospital for men and boys in the U.S., has replaced the small frame dwelling into which Brother Bonaventure carried his first patient from the street where he found him.

The hospitals in St. Louis and Elizabeth (N.J.) offer essentially the same services as those given in Chicago. Two of Brother Bonaventure's assistants, Brothers Paulus and Alexius, founded the St. Louis Hospital which now has 185 beds and last year provided treatment for 3,000 patients, including more than 300 in their well-equipped neuropsychiatry department. The 168-bed hospital in Elizabeth was founded in 1892 by Brothers Joseph, Aloysius and Constans. High on the list of its noteworthy achievements is a cerebral palsy clinic for both in-patients and out-patients which has been the subject of many medical papers concerned with the treatment of victims of this illness.

In addition to these three general hospitals for men and boys, the Brothers conduct a retreat for nervous and mental male patients at Oshkosh, Wisconsin, founded in 1880, and a rest house and resort for convalescents at Signal Mountain, established 12 years ago.

Through the centuries these modern Samaritans have "followed in the footsteps of Christ" by caring for the sick and the destitute. Today their work in preparing young men of all creeds for a career in nursing is an invaluable part of the nursing education program being carried on in this country.

Candid Comments

[*Continued from page* 28]

tells in the May issue of the *AJN* of the carefully coordinated studies she and her staff are making in developing nursing teams. One of the principles formulated out of their experience is: "That the make-up of the team—that is the number of professional and non-professional workers—should be determined by the needs of the patient."

When "the needs of the patient" is the central core to which we relate every problem in nursing, we shall find true and enduring answers. There is no doubt on my part that the majority of nurses are thinking and planning according to patients' needs. My plea is only that in the hurly-burly of today's events we keep our values straight, and this means staying very close to the realities.

Looming on the horizon is perhaps our most momentous question—the future of the diploma nurse, the present three-year graduate. There are those who believe that all the nursing needs of all patients can be met by trained practical nurses for bedside work, and university trained nurses for the supervisory and scientific functions. If ever a question called for considering factors beside those that can be put on paper, this is it.

Nursing has hidden values that no pencil can ever capture, but they are very real nevertheless. Diploma nurses have in the main brought the profession to its present important

place in the community. We see some of them efficiently meeting problems every day, the like of which would floor a bank president. We hear grateful patients and satisfied doctors demanding more of them. Three years of practical education in human relations and in meeting needs has given them something of extraordinary value, despite their lopsided education.

Lopsided preparation is the fault of the school, not the nurse. Is there any reason to believe that she has reached the end of her capacities simply because her school has? Wouldn't a better school, not necessarily a university, equip her in areas in which she is inadequate today? If our service is organized around patient needs, can bedside care remain in the hands of one-year trained people? And if that preparation is extended to the point of adequacy and safety for the patient, wouldn't we simply be changing the label of the diploma nurse but not her essential duties?

No one in her right mind wants wretched, poor and even fair schools continued. Only the best is good enough. But this best is achieved only when new objectives are harnessed to soundly established values.

In 16th Century Turkey only eunuchs were permitted to turn nurse—and could only care for male patients. If a woman became ill, or if she were near childbirth, all she could do was trust to her neighbors and pray to Allah all would go well.

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hypochondriasis (-kon-drī'ă-sis), *n.* hypochondria in its pathological aspect.
hypocrisy (hi-pok'ri-si), *n.* a feigning to be what one is not; dissimulation; [illegible] a profession.
hypocrite (hip'o-krit), [illegible] tices hypocrisy; a [illegible]
hypoderma, see [illegible]
hypodermic (hī[illegible] ing to the pa[illegible] hypodermis[illegible] subcutaneo[illegible]
hypodermi[illegible] beneath t[illegible]
hypoderm[illegible] dition [illegible] b[illegible]
hypoga[illegible]ric [illegible] ing to the hy[illegible]
hypoga[illegible]trium gastri[illegible] (-ă)], the [illegible] regio[illegible] of the abdome[illegible]
hypoge[illegible]al (hip-o-jē'al), *adj.* [illegible] the interior of the earth; subterranean.
hypoge[illegible]ous (-poj'e-nus), *adj.* growing on the under side of anything, as fungus on

hyposulphite (-sul'fīt), *n.* a salt of hyposulphurous acid.
hyposulphite of soda (sō'dă), a crystal[illegible] much used in photography as a
[illegible]ōr-us), *adj.* desig[illegible] oxygen than
[illegible] side of a
[illegible] the right
[illegible] to assign
[illegible] mortgage;
[illegible]ssion.
[illegible], *n.* the pledg[illegible] giving up posses[illegible]
[illegible]ing a ship; act of
[illegible]real estate for security
[illegible] (-poth'e-sis), *n.* [*pl.* hypothe[illegible]sēz)], something assumed for the purpose of argument.
hypothetic (-po-thet'ik), **hypothetical** ('i-kal), *adj.* based on hypothesis; conjectural.

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[Turn the page]

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INSTRUCTORS: Clinical and nursing arts. Teaching hospital, school now being established. Living accommodations consist of furnished suites in beautiful new apartment building. Middle West. RN7-12 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

INSTRUCTOR MEDICAL & SURGICAL NURSING: 500 bed General approved Hospital. Opportunity in two large Universities to further education. Apply Director of Nurses, Missouri Baptist Hospital, St. Louis, Mo.

LABORATORY TECHNICIAN (REGISTERED): Virginia location. $250 mo. Other attractive openings in this field. Medical Placement Service, 768 Juniper St., NE, Atlanta, Ga.

NURSE ANESTHETIST: $300 per month. Apply Director of Nurses, Cowlitz General Hospital, Longview, Wash.

NURSE ANESTHETIST: 340 bed A.M.A. and A.C.S. approved hospital. Department headed by physician anesthetist. Rooms avail-

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able in new Nurses' Residence. Mount Sinai Hospital, 2750 W. 15th Place, Chicago 8, Ill.

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NURSES: Staff nurses and supervisors for all departments. General hospital now being constructed in large city of foreign country. RN7-13 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

NURSES: Graduate nurses for psychiatric hospital in resort section of North Carolina. Salary in accordance with training and experience, including maintenance. Write Pinebluff Sanitarium, Pinebluff, N.C.

NURSES: Two, for interesting work among mountain whites. Excellent, up-to-date methods. Christian atmosphere, but non-sectarian. Apply to Grace Rood, R.N., Supt., Pine Mountain Hospital, Pine Mountain, Harlan County, Ky.

NURSING ARTS INSTRUCTOR: Vacancy Sept. 1. 130 bed hospital, 32 students. 40 hour week. Excellent personnel policies. Salary depends on preparation and experience. Apply Director of Nurses, Amsterdam Hospital, Amsterdam, N.Y.

NURSING ARTS INSTRUCTOR: $3600, maintenance. 125 bed general hospital. Midwest. (N216) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

NURSING ARTS INSTRUCTOR: With degree. Operating Room Supervisor and nurses for the Obstetrical Department. 154 bed hospital connected with a large clinic, located in the capitol city. Write The Bismarck Evangelical Hospital, 6th and Thayer, Bismarck, N. Dak.

NURSING OFFICE: Graduate nurse, supervising experience. 350 bed county hospital, Southern California. $250. 40 hour week. Business and Medical Registry (agency) 553 S. Western Ave., Los Angeles 5, Calif.

OBSTETRIC SUPERVISOR: Teaching responsibilities. 3 floor maternity wing, modern building. 58 bassinets. Salary open, depending upon qualifications of candidate. 44 hour week, 7 full holidays, 14 days' sick time annually. Generous vacation allowance. Live in or out. Write The Joseph Lawrence School of Nursing, New London, Conn.

OBSTETRIC SUPERVISOR: 240 bed general hospital located near Philadelphia, Pa. To have complete charge of floor, delivery room and nursery (40 mothers and 40 babies). Head nurse on each division. Advanced work and experience in obstetrics necessary. Salary open. 48 hour week. Liberal personnel policies. Apply Director of Nursing, Montgomery Hospital, Norristown, Pa.

OBSTETRICAL SUPERVISOR: Relatively new hospital, 200 beds. Department averages 25 mothers. Town, 35,000, short distance from university center, South. $3600. RN7-15 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill. [Turn the page]

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references:

1. Bridges, M. A.: Dietetics for the Clinician, Lea & Febiger, Philadelphia, 4th ed., 1941.
2. McLester, J. S.: Nutrition and Diet, Saunders, Philadelphia, 4th ed., 1944.
3. Rose, M. S.: Rose's Foundation of Nutrition, Rev. by MacLeod and Taylor, Macmillan, New York, 4th ed., 1944.
4. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, New York, 7th ed., 1946.

OBSTETRICAL SUPERVISOR: $3300 yearly. 40 hour week. 250 bed approved hospital. Midwest metropolis. (N154) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

OFFICE ASSISTANT: For medical director large co-educational college. Degree. Young. $3600 yearly. 40 hour week. One month annual vacation. (N302) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

OFFICE NURSE: Must be trained in laboratory and X-ray techniques. Well-established physician. Northwest. $4800 yearly. (T264) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

OPERATING ROOM SUPERVISOR: 150 bed approved hospital, Chicago suburb. $3000 maintenance. (N234) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

OPERATING ROOM SUPERVISOR: Six-room suite, 200 bed hospital. Building program will expand facilities. Large city of Southwest. Interesting offer. RN7-16 Burniece Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OPERATING ROOM SUPERVISOR: To reorganize entire department including teaching program. 300 bed hospital, southern New England City. Operating suites being completely renovated. Salary open. Paid vacations, 7 full holidays, sick leave. Apply Box JL-2 c/o R.N., Rutherford, N.J.

PUBLIC HEALTH SUPERVISOR: Wisconsin vacancy of supervisor in City Health Department. Generalized nursing program. Travel allowance. Bachelor of Science degree with a major in public health nursing. State beginning salary. Apply Dr. S. J. Stangel, 709 Washington St., Manitowoc, Wis.

REGISTERED NURSE: General night duty. 8 hrs., 48 hr. week, 12 to 8 a.m. shift. $200 per month with meals, uniform laundry. Large hospital offering retirement, insurance and vacation program to employees. McCleary Clinic & Hospital, Excelsior Springs, Mo.

REGISTERED NURSE: For student health service large western university. $2400 yearly, paid annual vacation. (N306) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

RESIDENT NURSE: Large eastern college attractively situated in New York resort region. $2000, maintenance. (N301) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

REGISTERED NURSES: All services or shifts in 150 bed general hospital. Straight 8 hour, 44 hour week. Vacation and sick leave with pay. Beginning $8.00 per day, $8.60 per evening or night. Inexpensive rooms in vicinity. Apply Director of Nurses, Glenville Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

REGISTERED NURSES: Basic salary $200 per month. Additional $10 for nights, $20 for evening shift. 40 hour week. $5 increase every six months until maximum of $50 is reached. $20 increase for Head Nurse. One month vacation granted after 1 year service. Holiday time. Write Nursing Service Direc-

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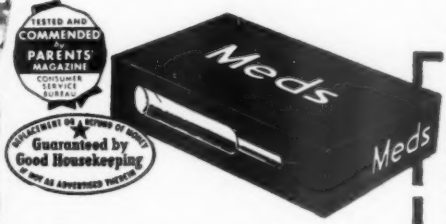

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tor, St. Elizabeth Hospital, Yakima, Wash.

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SCIENCE INSTRUCTOR: General hospital, 300 beds, situated few miles from New York City. Opportunity for continuing studies. Minimum $3000, complete maintenance. RN7-11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SCIENCE INSTRUCTOR: Vacancy Sept. 1. 130 bed hospital, 32 students. 40 hour week. Excellent personnel policies. Salary depends on preparation and experience. Apply Director of Nurses, Amsterdam Hospital, Amsterdam, N.Y.

SCIENCE INSTRUCTOR: $3600, maintenance. 250 bed approved hospital, eastern university town. (N160) Woodward Medical Bureau, 185 North Wabash, Chicago, Ill.

SCIENCE INSTRUCTOR AND NURSING ARTS INSTRUCTOR: For 150 bed accredited hospital. Requirements: degree in nursing education desirable, but advanced preparation with experience acceptable. Salary based on background and experience, maintenance if desired. Apply Director of Nursing Education, Laconia Hospital, Laconia, New Hampshire.

STAFF NURSES: Urgently needed. Salary $200-$240 plus premium pay. Signed contract includes paid holidays, vacation, sick leave, 5 day week. Cowlitz General Hospital, Longview, Wash.

STAFF NURSES: In Estes Park (Rocky Mountain) area, near Denver, Cheyenne. College town. Good salary, liberal personnel policy. New 200 bed unit in process of construction will provide unusual opportunity for advancement. Write Superintendent of Nurses, Weld County (General) Hospital, Greeley, Colo.

STAFF NURSES: 250 bed general hospital located in Central California. Attractive and comfortable nurses' home, air-conditioned. Starting salary $240 with $10 increase yearly for three years. Room cost $10 per month. Meals on meal ticket system 50c per meal. 40 hour week with 7 recognized holidays. 12 sick days yearly. We comply with all C.S.N.A. standards. Apply Director of Nurses, Merced General Hospital, Merced, Calif.

SUPERVISORS: Operating, obstetrical-gynecological and surgical floors. Teaching hospital operated under American auspices in foreign country. Transportation provided. RN7-14 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SURGICAL NURSE: Duties consist of scrubbing for plastic surgeon, Diplomate, American Board, on faculty, university medical school. RN7-17 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

X-RAY TECHNICIAN: $150 mo. plus maintenance. Florida hospital. Medical Placement Service, 768 Juniper St., NE, Atlanta, Ga.

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Full-year field check by 19 Universities* establishes significant data on food costs. Study compares COSTS AND AVAILABILITY of 12 commonly used Fruits and Vegetables in their four marketable forms—Fresh, Frozen, in Glass and in Cans.

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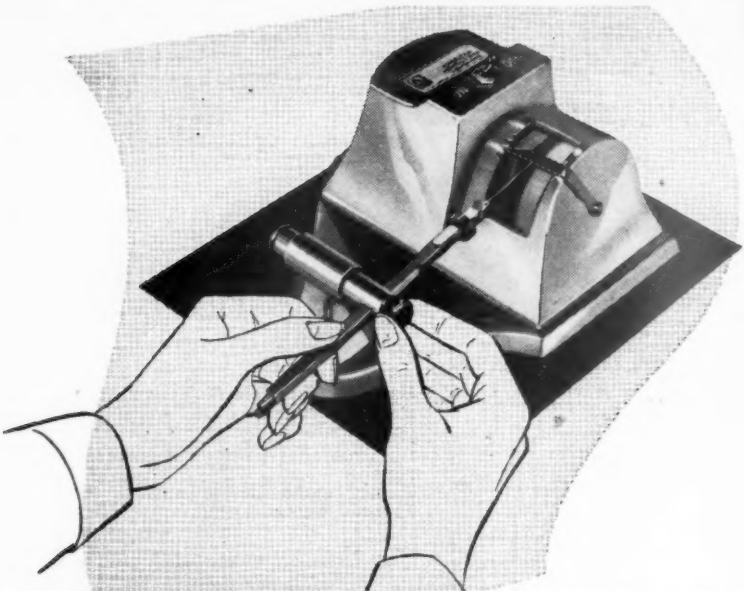

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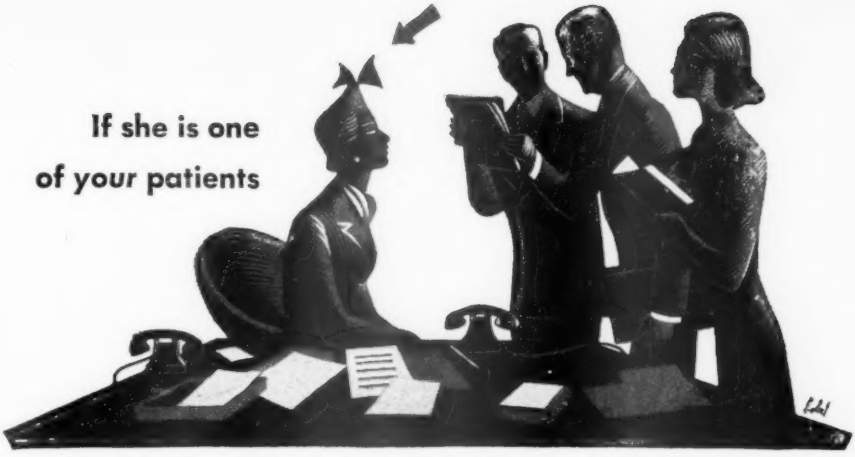

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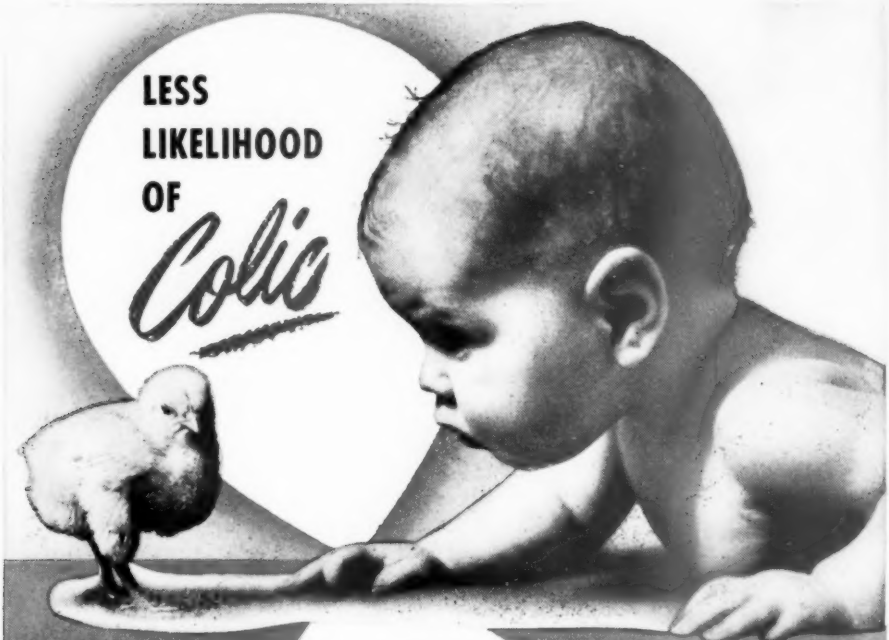

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